

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE





Digitized by the Internet Archive
in 2016

<https://archive.org/details/imjillinoismedic1411illi>

MAY 31 '71

JUN 14 '71

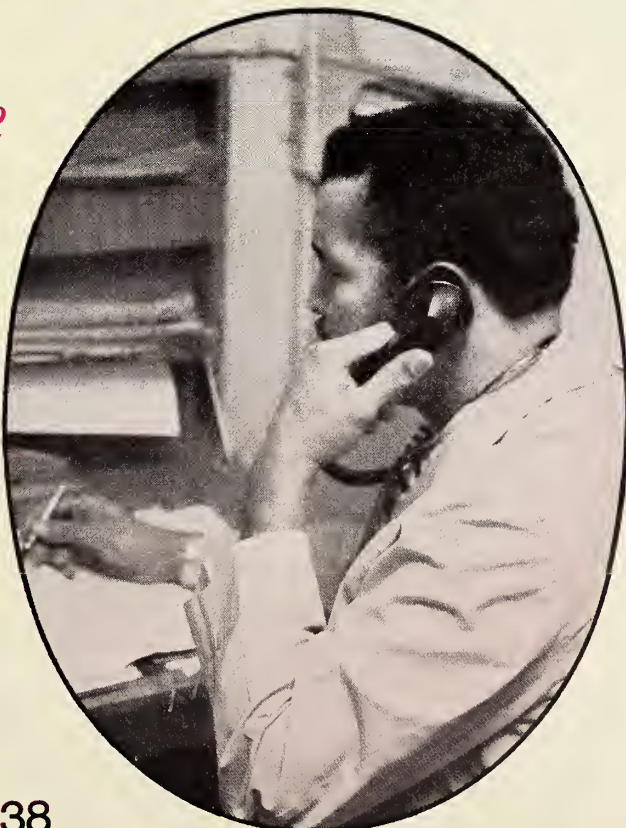
REC'D

LIBRARY

141 / No. 1 January, 1972



The Changing Face of Health Care Delivery



SEE PAGE 38

When diarrhea wrings the wedding belle...

It's all very well to counsel patience in diarrhea patients. There are times when relief of symptoms can't come too soon.

X-ray studies¹ in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.

Lomotil[®]

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contain:

Diphenoxylate hydrochloride . . . 2.5 mg.

(Warning: may be habit-forming)

Atropine sulfate 0.025 m.

Saves the Day



Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is classified as a Schedule V substance by Federal Law with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosage:



illinois medical journal

volume 141, number 1

January, 1972

staff	editor	Theodore R. Van Dellen, M.D.
	managing editor	Richard A. Ott
	assistant editor	Michaelyn Sloan
	advertising manager	John A. Kinney
	executive administrator	Roger N. White

Policy Manual of the Illinois State Medical Society	63
---	----

clinical articles	Lasting effects of early nutrition <i>Ellen S. Parham, Ph.D.</i>	27
	Management of congenital defects of the anterior abdominal wall <i>Hugh V. Firor, M.D.</i>	71
	Heart to head circulation time <i>Kenneth M. Campione, M.D.</i>	75

special articles	The changing face of health care delivery—ISMS Leadership Conference abstracts	38
	Status report: Illinois statewide trauma care system <i>David R. Boyd, M.D.C.M., Kenneth Mains, USN/FLT</i> <i>and Bruce A. Flashner, M.D.</i>	56

surgical grand rounds	Thymoma with myasthenia	33
--------------------------	-------------------------	----

features	the presidents page	6
	editorials	11
	the view box	32
	ekg of the month	37
	new pharmaceutical specialties	78
	clinics for crippled children	80
	socio-economic news	83
	pulse of the doctor's wife	84
	obituaries	85
	what goes on	89

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.



Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601. Copyright, 1972, The Illinois State Medical Society.

Subscription \$5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$7.50 per year for all foreign countries included in the Universal Postal Union. Canada \$5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.





The negative power of clinically significant anxiety.

This man thinks his next
quarrel may be his last.

For the hypertensive patient, severe symptoms may be intensified and aggravated by emotional overreaction to stress. Acutely aware of the adverse impact his emotions may have on the course of his life, the hypertensive patient's anxieties may be increased.

Adjunctive use of Libritabs may be of significant value in reducing excessive anxiety, which can induce adverse biochemical and physiological changes related to the vascular system and, by so doing, jeopardize management of the disease itself.

Libritabs (chlordiazepoxide) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is a significant component of the clinical profile.

Libritabs is especially well suited for extended use because of its wide margin of safety. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.) Moreover, the antianxiety benefits of Libritabs are generally maintained without diminution of effect or need for increase in dosage. When treatment is prolonged, periodic blood counts and liver function tests are advisable.

Libritabs (chlordiazepoxide) permits flexible, individualized therapy through its three oral dosage strengths.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmaco-

logic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**To relieve
excessive anxiety
in hypertensive patients
adjunctive**

Libritabs®
(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

t.i.d./q.i.d.
**up to 100 mg daily
for severe anxiety**



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



the presidents page

Doctors — Do you know where your candidates stand?

Illinois primary and general elections are just a few months away.

Do you know where YOUR local candidates stand on medical and health issues?

Well . . . you'd better find out! Legislators elected in the fall of this year will be writing legislation—some of it affecting physicians and the private practice of medicine—for years to come!

That's why the ISMS Public Affairs Committee encourages county medical societies to establish Candidate Interview Committees to interview all local candidates—incumbents as well as hopefuls.

The purpose of the interviews is NOT to promise endorsement to a particular candidate, but to inform! The interviews offer a unique opportunity for a two-way exchange of information. Physicians can inform candidates on vital medical and health issues, and candidates can tell physicians about their long-term programs, philosophies and goals.

The most effective communication takes place on face-to-face, one-to-one basis, and these interviews can be the basis for mutually beneficial relationships between physician and legislator.

So urge your county medical society to form such a committee. To be effective, all interviews must be completed by Feb. 15.

Logical committee members include chairmen of county legislation and public affairs committees, the local ISMS legislative Key-Man repre-

sentative, and physicians interested in preserving the health of their patients while insuring a medical profession unfettered by government inefficiency and red tape.

Be friendly, tactful and firm during the interviews. And don't be afraid to point out that results of the interview will be reported to medical society membership. Remind them that physicians are interested both in legislators and the political process.

During the general assembly just concluded, state and county medical societies in Illinois enjoyed legislative successes such as never before. But it didn't just happen. It took hard work by local physicians (Key-Men) throughout the state who communicated with legislators on issues vital to medicine.

During my President's Tour stops, many of these Key-Men told me they had always thought politicians weren't interested in hearing what we had to say. They were surprised to learn that legislators not only listen to our advice, but are glad to hear from a profession all too often silent in the past.

That's what we must do this year
SPEAK UP! We can do it through county medical society interview committees. Please . . . Form yours now!

L. J. Friedman

BLUE SHIELD REPORT



FOR *Illinois Physicians*

Bell System Employees Receive Greater Benefits

A broader scope of hospital and surgical-medical benefits plus a change from an Indemnity to a Usual and Customary Blue Shield certificate became effective January 1, 1972 for Bell System employees. The groups benefiting from this extended coverage are the Illinois Bell Telephone Company (IMS groups #51100 and #35500), Western Electric, Teletype, Bell Laboratories (IMS groups #1820 through #1835), and AT&T Long Lines (Central Certification Account #90338).

The major benefit increase was the change in the surgical-medical coverage from an Indemnity allowance to 80% of the Usual and Customary charges of physicians. Illinois Medical Service will now pay the physician 80% of his usual fee when this fee is "within the range of usual fees charged by physicians of similar training and experience" for covered services provided to patients holding these certificates. The patient is responsible for any difference.

Besides this change in the basis of payment, new areas of coverage (which vary slightly from group to group) have been added:

- **Care in Psychiatric Hospital**—Plan benefits are available for care in hospitals classified and accredited as psychiatric hospitals by the Joint Commission on Accreditation of Hospitals.

- **Assistant Surgeon**—Benefits are available for an assistant surgeon when such technical surgical assistance is medically necessary and there is no house staff available.

- **Consultations**—Coverage includes one consultation per specialty for a hospital inpatient when such specialized care is necessary.

- **Electro-Shock Therapy**—Benefits are available for electro-shock therapy provided on an inpatient basis, on an outpatient basis, or in a physician's office.

- **Outpatient Diagnostic X-ray and Laboratory**—The \$75.00 maximum per condition per year has been excluded. Benefits are now available without dollar limit for diagnostic X-ray and laboratory services consistent with the diagnosis or condition. No benefits are available for routine physical examinations.

Other coverage available under these certificates includes:

- **Surgery**—operative and cutting procedures including endoscopic procedures.

- **In-hospital Medical Care**—120 days of treatment not related to surgical or obstetrical care, including coverage of concurrent medical care when provided by a physician other than the surgeon or obstetrician for an unrelated condition.

- **Emergency Care**—treatment in the outpatient facilities of a hospital for accidental injuries within 72 hours of onset and for sudden and severe medical conditions.

- **Dental Surgery**—benefits for registered inpatients for dental surgery only when such treatment is a direct result of an accidental injury, removal of impacted teeth, or when a physician certifies that hospitalization is necessary to safeguard the health of the patient because of the existence of a specified non-dental organic impairment.

- **TB, Mental, Drug Addiction and Alcoholism**—30 days of treatment not related to surgical or obstetrical care.

- **Radiation Therapy**—treatment of disease by X-ray, radium or radioactive isotopes.

- **Maternity**—benefits for any female covered under the program after a waiting period of 270 days for any condition arising from pregnancy.

HELP FOR NEW MEDICAL ASSISTANTS

Do you have a new medical assistant in your office? Let Blue Shield help with her training.

A Professional Relations Representative is available to visit the new medical assistant and train her, in your office, in the correct method of completing a Blue Shield Physician's Service Report and a Medicare SSA 1490. Our representative can also answer questions your medical assistant might have about Blue Shield.

To arrange for a visit by one of our representatives, you or your assistant may call Mrs. Loretta O'Donnell at (312) 661-2964 or write to her at the Blue Shield Plan of Illinois Medical Service, Professional Relations Department, 222 North Dearborn Street, Chicago, Illinois 60601.

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Complete Information Needed on Medicare Claims

During 1971, Illinois Medical Service as a Part B carrier received more than 900,000 SSA 1490s, Request for Medicare Payment forms. The number of individual bills per claim was even greater. Of these more than 900,000 claims, more than 10 percent, or over 90,000, were delayed because the information of the claim was not complete.

Every item of information missing from the SSA 1490 delays the claim. A single missing item of information could delay the claim for days; other omissions could result in extended delays, sometimes for months. Our experienced claims examiners attempt to obtain as much information as possible by telephoning the physician. When letters have to be written, the delays are longer. Omissions also add to the administrative cost of the claim, both for the Part B carrier, who is required to obtain the information, and for the physician, who must review his records to provide it.

The three items most often missing from a Medicare claim are 1) the diagnosis, 2) the itemization of all charges, and 3) the itemization of specific charges.

The diagnosis is essential in order for the Part B carrier to relate the services provided to the treatment of the illness or injury. The diagnosis should be included on the physician's statement to the patient when billing the patient directly. This eliminates the necessity of contacting the physician for the diagnosis when the patient himself files for benefits and neglects to complete line 5 of the SSA 1490.

Itemization of all charges means to list the date of service, description of service, and charge for each service included on the SSA 1490 or statement to the patient. For example, a bill for several office visits plus in-hospital medical care should list the date and charge for each office visit plus the dates and charge for the in-hospital care.

Itemization of specific charges means to list the charges for each specific service included in an overall charge. For example, a charge for an office visit during which a complete blood count and an X-ray were taken should include the specific fee for the complete blood count and for the X-ray plus the charge for the office visit. Similarly, a charge for in-hospital visits should show the number of days the patient was visited and the charge for each day.

All statements presented to the patient should be itemized, including second and third statements.

Many times a physician will itemize the first statement to a patient and follow up with "For medical services, \$xx.xx". Patients will submit these follow up notices to us as a Part B carrier to claim benefits. We must then contact the physician for the charges, dates of service, diagnosis, etc. An itemized statement would eliminate this problem.

Listed below is the specific information which is required on all claims for Medicare benefits.

Part I of the 1490:

1. Complete name of patient as listed on the patient's Health Insurance Card.
2. Health Insurance Claim Number as it appears on the card, including the letter suffix.
3. Complete address and telephone number. This helps to establish the correct identity of the patient.
4. Sex. This enables us to know whether Johnnie Smith or Marion Jones is male or female.
5. Diagnosis and description of illness or injury.
6. Signature of patient.

Part II of the 1490 or attached bills:

1. Date of each service.
2. Description of each service.
3. Nature of illness or injury if not indicated in Part I.
4. Charge for each service.
5. Name and address of physician who provided the service. Please use the imprinted stickers which we have provided as these are specially coded to facilitate claim processing. If you need additional stickers, please contact us.
6. Whether or not the claim is assigned. If neither box is checked, we must assume that the claim is non-assigned and payment will be made directly to the patient (except for Public Aid patients).
7. Signature of the physician when assignment is accepted. A physician's signature does not guarantee assignment if the assignment box is not checked and/or the patient has not signed.

Please review all claims for completeness before submitting them to the Part B carrier (Illinois Medical Service for physicians in Cook County). By submitting correctly completed claims, you help us to speed payment to you or to your patient.

SSA Changes In Lab Certification

Newly certified laboratories:

1. Mediscreen Laboratory, 5 South Wabash, Chicago 60603.
2. E & M Medical Laboratories, Inc., 2600 South Michigan, Chicago 60616.
3. Mason-Barron Laboratories, Inc., branch office located at 40 South Clay Street, Hinsdale, Illinois 60521.

Laboratories no longer certified:

1. Mason-Barron Laboratories, Inc., branch office located at 1737 West Howard Street, Chicago 60626.
2. Bel-Aire Medical Building Laboratory, 8501 South Cottage Grove Avenue, Chicago 60619.

(This is not an advertisement)



editorials

HEW—A federal conglomerate

Every American, including members of the medical profession, has a stake in the Department of Health, Education and Welfare (HEW). The finances of this agency stagger the imagination. According to *Fortune Magazine*, HEW is a \$76-billion federal conglomerate whose 278 separate programs reach into each community and neighborhood; most of these plans are built around the growing assumption that a good education, protection against poverty and access to adequate medical care belong to every citizen, regardless of his own abilities and efforts. Our hat goes off to Elliot Richardson for taking on a thankless job—the administration of HEW.

The *Fortune* article divides the bureaucracy into six large parts. Our Food and Drug Administration has 4,667 employees and a budget of \$99.7 million. This is peanuts compared to the \$53.2 billion budget of the Social Security Administration (54,798 employees). The latter agency will pay out \$37 billion in social security benefits to 27 million people plus medicare benefits worth \$7.8 billion. This task requires 9,000 recordkeeping employees and the world's largest computer installation under one roof.

The Office of Education has 3,346 employees and a budget of \$5 billion, almost half of which is earmarked for "educationally deprived" children at the primary and secondary school levels. At the college level, \$1.3 billion is spent in student aid and grants to these institutions. The National Institutes of Health get \$1.7 billion

and employ 12,400 persons. Cancer is allotted \$338 million and Heart and Lung, \$232 million. In all, there are 10 research institutes. Much of the research is conducted in the nation's medical schools. Annually, one-half billion is spent on medical school construction.

Health Services and Mental Health has a budget of \$2 billion and 27,371 employees. This department is responsible for health care delivery, including control of epidemics, mental health services, family planning and collection of vital statistics. It also administers grants for hospital construction under the Hill-Burton Act. The newly authorized National Health Service Corps will aid low-income communities and areas of the country losing population.

The Social and Rehabilitative Service (SRS) disburses some \$10 billion annually in payments and medicaid services to about 14 million people. If Congress approves the family assistance program, a new agency, 30 times as large as SRS will be created to take over many state and local welfare functions.

This is only one department headed by a Cabinet officer. We shudder to think what a major depression might do to our bureaucracy in Washington.

T. R. Van Dellen, M.D.
Editor

Juan Cameron: "A Boston Brahmin in 'Heart-break House'," *Fortune*, Oct., 1971, pgs. 88-91, 160, 162 and 167.

Guest editorial

Giving to AMA-ERF

Ten thousand members of the Illinois State Medical Society have set a challenging example

for other physicians.

They have contributed \$180,000 to the American Medical Association Educational Foundation.
(Continued on next page)

Giving to AMA-ERF

(Continued from page 11)

can Medical Education and Research Foundation this year.

As John M. Chenault, M.D., the president of AMA-ERF, noted in his report to the AMA House of Delegates at the Clinical Convention last week, that total represents \$20 per member of the Illinois society.

"When I was informed of this gift," Dr. Chenault remarked, Illinois' "generosity so impressed me that I calculated the amount of money which would be realized if every dues paying member of AMA would contribute a like amount, the sum would be over \$2.8 million—more than three times the amount contributed by physicians and the Auxiliary last year."

In addition to the check for \$180,000, 252 Illinois physicians responded to AMA-ERF's direct mail campaign this year by contributing \$13,756 directly to AMA-ERF, and over the past 18 years the members of the Illinois State Medical Society have contributed more than \$3 million to medical education through AMA-ERF. Many physicians and many state medical societies and their auxiliaries have contributed generously to AMA-ERF, but none has a more exciting record than does Illinois.

In the first nine months of 1971, Dr. Chenault reported, AMA-ERF received \$551,000 earmarked for medical schools, \$302,000 designated for its loan guarantee program, \$75,000 for unrestricted use, and \$132,000 for its deserving needy students interest free loan program. This totals \$1,060,000. Current estimates, Dr. Chenault said, are that AMA-ERF's 1971 income will exceed that of 1970.

The new program to guarantee interest free loans to deserving needy students is now operating in the state of California and AMA-ERF is eager to extend it to all states as quickly as funds will permit.

As Dr. Chenault's report indicates, AMA-ERF continues to write exciting records and be a major source of funds for medical education. But those who are involved in the Foundation's work cannot help but dream with Dr. Chenault of the tremendous effect that could be achieved if every dues paying member of the AMA matched Illinois' record.

Reprinted with permission from the American Medical News, December 6, 1971 issue.

PFIZERPEN® VK

(POTASSIUM PHENOXYMETHYL PENICILLIN)

ACTIONS: Microbiology: Phenoxyethyl penicillin exerts high in vitro activity against staphylococci (except penicillinase-producing strains), streptococci (groups A, C, G, H, L, and M) and pneumococci. Other organisms sensitive to phenoxyethyl penicillin are *Corynebacterium diphtheriae*, *Bacillus anthracis*, *Clostridia*, *Actinomyces bavis*, *Streptobacillus moniliformis*, *Listeria monocytogenes*, *Leptospira*, and *Neisseria gonorrhoeae*. *Treponema pallidum* is extremely sensitive. Pharmacology: Phenoxyethyl penicillin is more resistant to inactivation by gastric acid than penicillin G. It may be given with meals and average blood levels are two to five times higher than the levels following the same dose of oral penicillin G. Once absorbed, phenoxyethyl penicillin is about 80% bound to serum protein. Tissue levels are highest in the kidneys, with lesser amounts in the liver, skin, and intestines and small amounts in all other body tissues and cerebrospinal fluid. Only about 25% of the dose given is absorbed. In neonates, young infants, and individuals with impaired kidney function, excretion is considerably delayed.

INDICATIONS: Phenoxyethyl penicillin is indicated in the treatment of mild to moderately severe infections caused by penicillin G-sensitive microorganisms that are sensitive to the low serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response. Culture and sensitivity testing are especially important in suspected staphylococcal infections because increased resistance has been reported. Phenoxyethyl penicillin is not active against penicillinase-producing bacteria.

Note: Severe pneumonia, empyema, bacteremia, pericarditis, meningitis, and arthritis should not be treated with phenoxyethyl penicillin during the acute stage.

Indicated surgical procedures should be performed.

Medical conditions in which oral penicillin therapy is indicated as prophylaxis: For the prevention of recurrence following rheumatic fever and/or chorea, to prevent bacterial endocarditis in patients with congenital and/or rheumatic heart lesions who are to undergo dental procedures or minor upper respiratory tract surgery or instrumentation.

Note: Oral penicillin should not be used as adjunctive prophylaxis for genitourinary instrumentation or surgery, lower intestinal tract surgery, sigmoidoscopy and childbirth.

CONTRAINDICATION: A previous hypersensitivity reaction to any penicillin.

WARNINGS: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. While more frequent following parenteral therapy, anaphylaxis has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

Some individuals with a history of penicillin hypersensitivity reactions have experienced severe hypersensitivity reactions from a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines and corticosteroids.

PRECAUTIONS: Penicillin should be used with caution in individuals with histories of significant allergies and/or asthma.

The oral route of administration should not be relied on in patients with severe illness, or with nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts of orally administered penicillin.

In streptococcal infections, therapy must be sufficient to eliminate the organism (10 days minimum); otherwise the sequelae of streptococcal disease may occur. Cultures should be taken following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms, including fungi. Should superinfection occur, appropriate measures should be taken.

ADVERSE REACTIONS: While the incidence of reactions to oral penicillins is much less than with parenteral therapy, it should be remembered that all degrees of hypersensitivity, including fatal anaphylaxis, have been reported with oral penicillin.

The most common reactions to oral penicillin are nausea, vomiting, epigastric distress, diarrhea, and black hairy tongue. The hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema, and anaphylaxis. Fever and eosinophilia may frequently be the only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy, and nephropathy are infrequent reactions and are usually associated with high doses of parenteral penicillin.

HOW SUPPLIED: Pfizerpen VK (potassium phenoxyethyl penicillin) for Oral Solution. Each 5 ml. of reconstituted solution contains potassium phenoxyethyl penicillin equivalent to 125 mg. (200,000 units) or 250 mg. (400,000 units) of phenoxyethyl penicillin.

125 mg. bottles of 100 ml. and 150 ml.
250 mg. bottles of 100 ml. and 150 ml.
Pfizerpen VK (potassium phenoxyethyl penicillin) Tablets. Each tablet contains potassium phenoxyethyl penicillin equivalent to 250 mg. (400,000 units) or 500 mg. (800,000 units) of phenoxyethyl penicillin.
250 mg. bottles of 100.
500 mg. bottles of 100.

More detailed professional information available on request.



LABORATORIES DIVISION
PFIZER INC. NEW YORK, N.Y. 10017



I M J

Illinois Medical Journal

Vol. 141, No. 1, January, 1972

BY ELLEN S. PARHAM, PH.D./DEKALB

Lasting effects of early nutrition

For years, due to the difficulties of longitudinal and metabolic studies of human beings, nutritionists have had to content themselves with observations of relatively short-term effects of nutrition, knowing that thereby they were really concerning themselves with the "trees," but missing the "forest." In the last few years, new techniques, particularly in the study of growth at the cellular level, have permitted new understanding of the role of nutrition in the overall process of growth and development. In many cases, certain characteristics of the adult individual were found to have their origin in early feeding patterns. For example, adult mental retardation, obesity, hypertension, and atherosclerosis have been linked to infant nutrition.

Traditionally, growth has been monitored by the rather gross techniques of measuring weight and height. New techniques which allow the determination of numbers of cells and of cell size have opened the door to better understanding of the role of nutrition in growth. These techniques are based upon the fact that the amount of DNA is consistent within all diploid cells of a species. Knowing that in the human each cell contains 6.0 pica grams DNA,¹ one can analyze the amount of DNA in a tissue sample and then calculate the number of cells in the tissue or organ. Therefore, statements of the total amount of DNA per organ reflect the number of cells in that organ. Cell size can be determined by calculating the ratio of total organ weight to total DNA.

Utilization of these DNA determinations has shown that growth at the cellular level always follows a pattern of three phases: The first phase, hyperplasia, is characterized by rapid increments of DNA, indicating a major increase in cell numbers. At this stage the cell size is constant. Next follows a transition phase during which the rate of increase in cell numbers begins to slow down and the cell size and amount of cellular protein begins to increase. The third phase, hypertrophy, involves increase in cell size with cell numbers remaining constant.

Hyperplasia-Vulnerable period

Apparently, the order of the growth phases is the same for all species and for all tissues. However, there are great differences in the timing or

Early nutrition

duration of each phase from tissue to tissue and from species to species.² In all organs, hyperplasia seems to continue throughout prenatal life and, in some organs, for varying periods postnatally. Cell division stops first in brain and lung tissue and last in muscular tissue like skeletal muscle and the heart. The weight or size of tissue are very poor indicators of the stage of growth.

Apparently the tissue undergoing hyperplasia is highly susceptible to environmental influences, including nutrition. Undernutrition at this stage results in a reduced number of cells which do not increase in number when the animal later receives a good diet. Winick and his co-workers observed that rats, underfed from birth to 20 days of age, had reduced numbers of cells in all organs, as well as overall growth retardation; refeeding later was ineffective.³ Underfeeding of another group of rats during their 64-86 days produced normal cell numbers, but small cell size. These rats recovered normal cell size during a subsequent refeeding period. Rats, underfed during their 21-42 days, showed cells normal in number but decreased in size in brain and lung. These tissues recovered normal cell size during refeeding. Other tissues had reduced cell numbers and showed no recovery. Similar results have been observed in other laboratories.

The stage of hyperplasia, thus, has come to be regarded as the vulnerable period of growth. Because tissue seems so susceptible to undernutrition at this time and because the deleterious effects appear irreversible, it becomes extremely important to identify when hyperplasia occurs and to monitor nutritional conditions at that age.

The influence of nutrient supply, especially protein and calories, during hyperplasia has been demonstrated in several species and to some extent in humans. Nutrition at this stage has been implicated as a factor in adult body size, including degree of fatness and brain size (and possibly brain functioning).

Mental development

The existence of a relationship between nutrition and mental development has caught the public fancy. Lay publications have discussed the subject as though it were a simple cause and effect situation. The investigators in the field, however, are more cautious, feeling that there are still too many unanswered questions. The studies

thus far have been of three types: animal experiments; retrospective or prospective studies of inadvertently malnourished children; and general observations of populations whose diets differ in quality. Each type of study has its weaknesses, but, in general, they seem to produce similar conclusions—undernutrition at the critical period of brain growth affects brain size, as indicated by lower brain weight, fewer brain cells, or smaller head circumference than well-fed controls. Although some investigators attempt to show a correlation between brain size and mental performance, it is difficult to rule out other factors, and many workers have confined their observations to the role of nutrition on brain size and have left speculation as to the implications for intelligence to the psychologists and educators.

Certainly, the most carefully controlled work has been done with laboratory animals. However, findings with animals cannot be directly extrapolated to humans without taking into consideration the species differences and differences in the nature of the environment. Primarily, the various species differ in the timing and rate of brain growth. For example, the rate curve for brain growth in the rat peaks well after birth, whereas both man and the pig experience most rapid brain growth in the interval immediately before and after birth.⁴ The rat is a convenient experimental animal because it is far easier to alter nutrition postnatally than prenatally. However, one must bear in mind that the human brain is much more mature and less vulnerable in the neonatal period than is the rat brain. Despite these differences, Dobbing² feels that animal experimentation is useful in elucidating the nature of the response of brain tissue to undernutrition at various phases of growth. This qualitative information can then be applied to other species relative to their own timetable of brain growth. Winick^{1,3} states that the vulnerable period for the human brain is the last few prenatal weeks up to the sixth postnatal month. Dobbing² believes that some increase in brain cell size continues through the eighteenth month.

Pre- and postnatal environments

Both prenatal and postnatal environment also differs among species. Although there is much yet unknown about prenatal nutrition, there is indication that the human fetus is a relatively

efficient parasite.^{5,6} A human fetus averages, at birth, six per cent of his mother's weight, whereas the rat litter is equivalent to about 25% of the maternal weight.⁷ In animals like rats and guinea pigs, the fetal nutritional demands upon the mother are tremendous; near term the young incorporate into their bodies amounts of calcium and phosphorus equal to the whole of those minerals circulating in their mother's serum every hour.⁵ During the last trimester, the human fetus requires five per cent of the total calcium and 10% of the inorganic phosphorus in the plasma of the mother every hour.⁵ There has been no attempt to relate mineral nutrition to prenatal brain growth, but these figures serve to illustrate species differences in the burden of fetal nourishment upon maternal stores and supplies.

Postnatally, the human situation is vastly more complicated than that of the laboratory animal. Among humans malnutrition is usually accompanied by other stresses, such as infection or neglect. Therefore, observations of laboratory animals can do little more than point the way for appropriate studies of humans.

Effects of malnutrition

Many investigators have observed that malnourished children in less developed countries exhibit retarded physical and mental development. Winick and Rosso³ analyzed brains of Chilean children, comparing brain weight, cell number, and cell size between nine children who had died of marasmus during their first year and eight well-nourished children of less than one year who had died from accidents. The brains of the well-fed children were comparable in every measure to those of normal American children. Among the children dying of malnutrition, the brain weight, cell number, and cell size were reduced. The conditions of the experiment made it impossible to determine what effect less severe malnutrition would have had on brain growth.

Although many scientists will concede that malnutrition severe enough to interfere with brain growth occurs in the poorer parts of the world, they frequently question whether the necessary conditions exist in the United States. Chase and Martin⁹ recently showed, among previously malnourished Denver children, developmental conditions similar to those observed in the less developed countries. They studied the mental and physical development and home situations of 19 children who had been treat-

ed approximately three years earlier for undernutrition. Nine of these children were treated when they were less than four months old; since they were not readmitted later, it was assumed that the situation had improved and that they experienced no further severe undernutrition. The ten children who were treated between their fourth and twelfth month were assumed to have endured a longer period of undernutrition. These previously undernourished children were compared to a control group drawn from the same socio-cultural background. The previously undernourished children were smaller; those treated after four months were significantly lower than the control children in height, weight, and head circumference. Administration of the Yale Revised Developmental Examination resulted in mean development quotients of 99.4 among the control children, 95.1 among the children undernourished before four months, and 70.3 among the children undernourished after four months of age. All five areas of development among the children malnourished the longest were significantly lower than among control children or among children undernourished before the fourth month. Poor development in language skills was particularly evident.

Examination of family social functioning revealed that the families of the control children and of the previously undernourished children had similar problems, but the severity was frequently greater in the test families. The families of the previously undernourished children had more children, more closely spaced, more alcohol problems, more economic problems during the child's first year, and a higher rate of desertion by the father during the pregnancy. Eighty-eight percent of the mothers of the test children indicated that these children were the product of unwanted pregnancies.

Chase and Martin coined the expression "psychonutritional deprivation" to describe the situation which had produced the undernutrition they had observed. A prime example of this deprivation was the case of a pair of monozygotic twins. Twin A was not malnourished and at two and a half years he had a developmental quotient of 80. Twin B was named after his father who had deserted the mother during pregnancy.

ELLEN S. PARHAM, Ph.D., is assistant professor in the Department of Home Economics at Northern Illinois University.

Early nutrition

He was treated for undernutrition at three months and again at two years. His developmental quotient was 40 points below that of his twin. Twin A weighed 40% more and was three inches taller than Twin B.

Obviously, it is quite impossible in most observations of humans to separate the effects of malnutrition from those other environmental influences affecting mental development. Scrimshaw¹⁰ states that there is interaction between early infection, early malnutrition, and early sensory and cultural deprivation such that one contributes to the others and each may directly or indirectly lead to retarded growth and development and to impaired performance on tasks of learning and adaptive behavior. Unfortunately, an environment which involves malnutrition usually includes poor sanitary conditions and minimal sensory and cultural stimulation, as well.

Thus, it is currently not possible to assess quantitatively the impact of early malnutrition upon adult intelligence among humans. Nevertheless, there is strong evidence that malnutrition at the period of brain hyperplasia causes reduced brain size and that an unfavorable early environment, including malnutrition, frequently produces impaired mental performance.

Malnutrition can be interpreted, not only as nutrient deficiency, but also as oversupply of nutrients. Certainly, over-nutrition, especially over-consumption of calories, is as real a problem as is under nutrition in the United States.

Over-nutrition

Jules Hirsch and his colleagues¹¹⁻¹³ have been pioneers in research showing that growing adipose tissue is vulnerable to over-nutrition during hyperplasia. These workers employ a technique of actually counting the numbers of fat cells in a tissue sample. Studying fat tissue from extremely obese persons, they found that the size of the fat depots was due primarily to fat cell number rather than cell size.^{11,12} The numbers of fat cells were greatly increased over those of normal weight persons. Adherence to a diet furnishing 600 Cal./day reduced the size of the fat depots and the size of the individual fat cells, but the number of fat cells remained constant. Similar results were obtained with adult rats.¹¹ Both starvation and refeeding affected fat cell size, but not cell number. The question arose as to why, if the number of fat cells is so

resistant to dietary manipulation, do such wide variations in numbers occur between obese and normal weight persons?

This question was largely answered by subsequent dietary manipulation of newborn rats.¹³ These newborn rats were either over-nourished by assigning four pups to a lactating dam or undernourished by giving one mother 22 pups to nurse. After weaning, all animals had free access to the same diet. Significant differences in overall weight and in size of epididymal fat pads were seen at weaning; these differences increased with time, up to a maximum when the study was terminated at 20 weeks. In vitro incubation of fat tissue with labeled glucose 14C and determination of CO₂ and triglyceride production showed that fat cells converted glucose at comparable rates, regardless of cell size. The total glucose conversion was a function, therefore, of number of fat cells, rather than total amount of adipose tissue, or fat cell size. Hirsch and his coworkers feel that more study of the relationship of lipid metabolism to cell size and number is needed.

Later studies¹¹ with older rats showed that altering dietary intake at six weeks of age had no effect on adipose cell number. Likewise, after seven and a half weeks of age, hypothalamic lesions in rats resulted in gross fat accumulations, but no change in cell number. Therefore, it would appear that the vulnerable period, hyperplasia, for rat fat tissue occurs before six weeks of age. The timing of the vulnerable period for humans has not been determined, but many pediatricians have suggested that this phase occurs within the first year of life.

Eid¹⁴ studied, among 224 English children, the relationship of weight gain during the first six months of life to weight at six to eight years of age. The incidence of fatness at follow-up was 20.3% among children who had been above the 90th percentile as infants and 6.9% among those whose infancy weight was about the 50th percentile or lower. Of those who had gained excessively by the sixth week of life, 18.5% were later obese or overweight. Among those whose excessive weight gain was detected only at six months 26.7% were overweight or obese. The relationship of birth weight to later weight was not clear. Weight gain in infancy was a better predictor of overweight than birth weight or parents' weight. There was no significant difference between breast-fed and artificially-fed ba-

bies with regard to later obesity. No further investigation of the dietary history of the children was made. Apparently, among these children the mechanisms of obesity came into action after birth, but before the individual was six months old. Hirsch's work would suggest that one of these mechanisms would be an increased number of fat cells which may influence metabolism and appetite. Obviously, there is much work to be done.

Studies of the influence of early feeding on adult obesity are still in their infancy. Yet one cannot help but speculate upon the practical implications. Since animal studies have shown repeatedly that overfeeding after maturity can cause fat accumulation associated with increased cell size, one would expect similar findings among humans. There may be persons whose obesity is due to increased cell numbers, to increased cell size, or to both. Further findings about the relationship of cell size to fat metabolism might suggest that treatment of these variations of obesity needs to be matched to the nature of the fat tissue. The tendency of formerly obese persons to regain weight losses may be related to the greater energy efficiency of abnormally large numbers of fat cells; the metabolic deviations may influence hypothalamic control of appetite. Because of the role of insulin in fat metabolism and because of the predisposing effect of obesity on diabetes, it should be enlightening to study number and size of fat cells among persons with brittle and maturity-onset diabetes.

Summary

The possibilities for speculation are practically endless, especially when one considers that, to this time, studies of nutrition on cell growth have been largely restricted to energy and protein. There have been some studies of the relationship of early sodium intake to later hypertension.¹⁵⁻¹⁷ Among rats, the earlier the introduction to a high sodium diet, the greater the incidence and severity of hypertension. The diet of the modern infant, cow's milk and commercially-prepared baby foods, greatly exceeds his sodium needs. Studies of sodium and hypertension and of lipids and atherosclerosis support the hypothesis that many of the subtleties of infant feeding have far-from-subtle consequences in adulthood. However, little or no work has been done on the influence of these nutrients on growth at the cellular level.

What work has been done provides a fascinating long view of nutrition. However, one can still not interpret this long view into dietary modifications. There is definite indication that we can no longer be content with gross assessments of nutrition and health in infancy. The "common sense" approach, that if baby is "fat and pretty" all is well, will no longer suffice. ◀

References

The bibliography for this article can be obtained by writing to *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago 60601.

ISMS endorses lead poisoning prevention

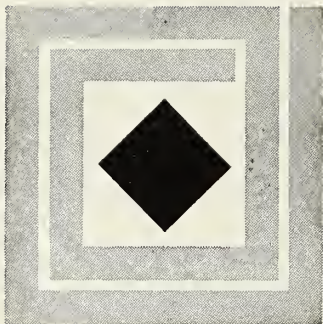
Recent publicity on the presence of lead levels ranging above tolerable minimum levels in many children prompted the School Health Sub-Committee to adopt the following statement, which has been endorsed by the ISMS Council on Environment and Community Health and the Board of Trustees:

The Illinois State Medical Society urges county medical societies to cooperate with the American Academy of Pediatrics in exploring effective programs for the prevention of lead poisoning in their areas.

ISMS endorses—and urges prompt implementation—of Public Law 91-695 which provides grants for the detection, treatment and elimination of lead-based paint poisoning, fed-

eral demonstration and research programs, and prohibits the use of lead-based paint in future federal construction and rehabilitation of residential buildings. Extensive local education programs are part of this bill which authorizes a total of \$30 million for the fiscal year 1971 and 1972.

Since lead intoxication apparently is a widespread problem in both the urban and rural areas, ISMS will make every effort to inform physicians on its severity and early detection. The State Medical Society also offers its cooperation to the Illinois State Department of Public Health in its new public education campaign on lead poisoning prevention.



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This eight-year-old boy fell from a height with resultant gross hematuria. An IVP was done. (Fig. 1) What's your diagnosis?

1. Contusion of the bladder
2. Intraperitoneal rupture of the bladder
3. Extraperitoneal rupture
4. Perivesical hematoma

(Continued on page 82)



surgical grand rounds

EDITED BY JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 26, 1971.

Thymoma with myasthenia

Dr. John Eilert: A 61-year-old white female had complained of progressive subjective weakness and exertional dyspnea and some right-sided chest wall pain for one and one-half years prior to admission. She had been evaluated in another hospital where bronchoscopy and a scalene node biopsy had been performed for an anterior-superior mediastinal tumor that was found on a chest X-ray, taken when the lady was being evaluated for repair of a recurrent cystocele. She was brought into Passavant in a state of almost complete subjective fatigue. She stated that she was unable to do any kind of work at all, and could not walk or stand without assistance. At the time of admission, physical examination was entirely unremarkable. Despite the history of progressive weakness, demonstrable muscle weakness was absent. The neurology service performed a Tensolin test which was equivocal. Electromyographic studies were compatible with myas-

thenia gravis, although clinical evidence was absent. Pulmonary function tests were normal. Chest X-rays were obtained.

Dr. Harold Mathis: We reviewed an article which reported 29 cases of thymoma without a single instance of myasthenia gravis. The patient under discussion today has an anterior superior mediastinal tumor without tracheal displacement (Figs. 1 & 2). The mass is visualized best by the use of tomography (Fig. 3). It does not appear to be thyroid. Other lesions of the anterior superior mediastinum include teratoma, normal thymus, tumors and cysts of the thymus, lipoma, fibroma, and vascular tumors. The lobulated, well-demarcated appearance of this lesion points to a diagnosis of thymic tumor.

Dr. Eilert: She was taken to the operating room, where through a median sternotomy a thymoma was excised. It was adherent and invading the

Thymoma with myasthenia



Figure 1. AP view of chest demonstrates superior mediastinal mass without deviation of the trachea.

left innominate artery, and for that reason, it was impossible to remove the entire tumor. Radiation treatment to the mediastinum has been initiated postoperatively. The postoperative course has been entirely unremarkable, and she has subjective improvement of her generalized weakness.

Dr. Thomas Shields: This was an interesting patient. When I initially saw her, she was almost carried into the examining room by her two daughters, and her major complaint, in addition to her weakness, was anterior chest wall pain. Immediately when confronted with the complaint of pain in the presence of a mediastinal mass, one thinks of a malignant tumor, and, with the very severe weakness which she presented, this would either be a malignant thymoma or a carcinoma of the lung with mediastinal metastasis and a myasthenic-like syndrome. With these initial thoughts, it was believed that she was probably not a candidate for anything, other than a diagnostic evaluation and then roentgen therapy. However, as time progressed in the hospital, it became apparent that the chest wall discomfort wasn't really true pain and that her weakness was subjective rather than real, and, as pointed out by Dr. Eilert, none of the clinical

muscle testings confirmed the presence of myasthenia. The neurology service saw her and the Tensolin test was equivocal as mentioned. Electromyographic studies, however, were positive for myasthenia. Initially, I didn't even subject her to pulmonary function studies, because I thought she wouldn't even be able to perform a meaningful examination; however, after she had improved while being evaluated, we then decided to conduct these and the results were perfectly normal.

Most people believe that these patients, if they do, indeed, have true myasthenia and have not been on medication, should not be placed on medication prior to surgery, or, if they have been on medication for myasthenia, the medication should be stopped just prior to operation. This is so that one can judge more accurately how the patient responds post-operatively, rather than having to make the decision between a myasthenic crisis or a cholinergic crisis. She has absolutely no trouble postoperatively and her weakness miraculously disappeared.

At operation, the tumor was exposed through a median sternotomy and was a moderately-sized



Figure 2. Lateral view of chest demonstrates anterior location of superior mediastinal mass.

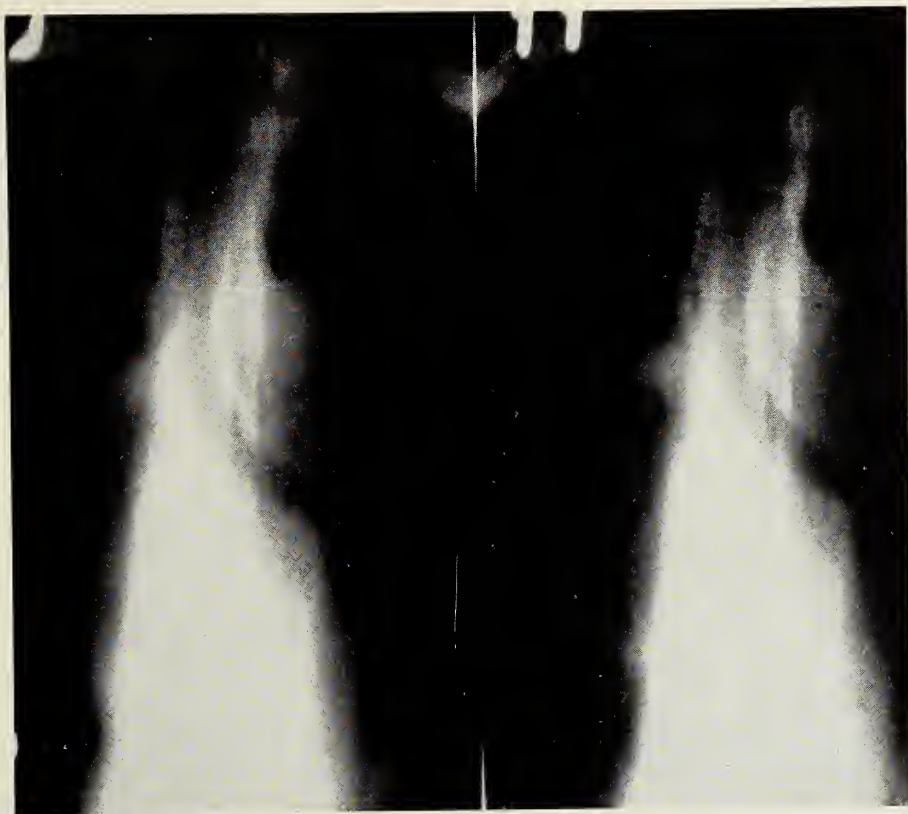


Figure 3. Tomograms of mediastinum demonstrate the lobular nature of the thymoma.

thymoma. There was local infiltration posteriorly, and a small piece of tumor was left behind on the left innominate vein. Grossly, this tumor was classified as being a locally invasive thymoma.

Dr. Hector Battifora: This tumor was diagnosed as a thymoma, without stating whether it was benign or malignant, which I think was a very wise thing to do because on histological grounds alone, this distinction can seldom be made. Gross evidence of infiltration of neighboring organs is more helpful in establishing malignant behavior, and conversely encapsulated tumors tend to be benign in their course. The typical appearance of thymoma is shown by this tumor. There is formation of nodular masses of varying sizes separated by broad trabeculae (Fig. 4). Essential to the diagnosis of thymoma is a combination of two types of cells, epithelial and lymphoid. In most tumors, as is the case here, an even admixture of these cell types is found. In some cases one cell type may predominate. If the lymphoid cells predominate, a differential diagnosis with primary thymic lymphoma might be difficult.

Dr. Shields: In reference to what Dr. Mathis

said about the report of 29 patients with thymomas and no instances of myasthenia, in my own group of over 20 patients with thymoma I have had 2 patients with myasthenia, so the incidence is about 10%. However, in a recent report from the Mayo Clinic group of over 230 thymomas, there was a 50% incidence of associated myasthenia gravis, which certainly is not seen as a general rule. This is strictly the result of selectivity of patients which are sent to the Clinic, and unfortunately, unless a footnote is made that this is an abnormal selection of patients, everybody begins to believe that half the patients with thymomas have myasthenia, when actually it probably is more like 10%.

Benign tumors are readily removed, and frequently there is not even a vascular pedicle present. When benign, there is a survival of almost 100%, if they do happen to have myasthenia, the prognosis is worsened because of the combination, particularly because of the myasthenia *per se*.

The next group of patients with thymomas are those that have locally invasive tumors which may involve one or more of the adjacent structures—pericardium, pleura, or great vessels. In this situation I take out all the tumor I can

Thymoma with myasthenia

without sacrifice of a vital structure, and then submit the patient to roentgen therapy. Numerous five year survivals have been reported with this particular approach.



Figure 4. Microscopic examination demonstrates typical pattern of thymoma.

The last group of patients with thymomas are those whose tumors are frankly malignant. Such patients come in with pain in the chest, severe vena caval obstruction, or they may have pleural effusion. All these patients do poorly regardless of the type of therapy that is employed.

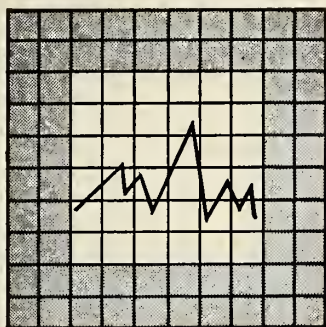
Dr. James Hines: I have a question in reference to therapy. If myasthenia occurs in a patient with a thymoma, is surgical procedure indicated, or as some people suggest under such circumstances, should radiation be the primary mode of therapy?

Dr. Shields: There is the suggestion in the literature that if the patient has a small thymoma and myasthenia, these patients should be treated with radiation. Whether this radiation should be preoperative or the total therapeutic approach is under question. One thing is certain—patients who have myasthenia and a tumor, have a much worse prognosis than patients with myasthenia alone, or a benign thymoma and no myasthenia.

The question as to the role of thymectomy in patients with myasthenia is still a terribly controversial subject. At the Mayo Clinic, where surgeons have had probably the most experience outside of Boston and Baltimore, thymectomy is continued in patients who no longer continue to respond to their medical therapy. The ideal patient, of course, is the patient without thymoma, a young woman under the age of 40, who after a short duration of the disease for some reason does not respond any longer to her medication. However, despite the fact that this represents the best group, some surgeons still use thymectomy in older women and also in men with this disease. ◀

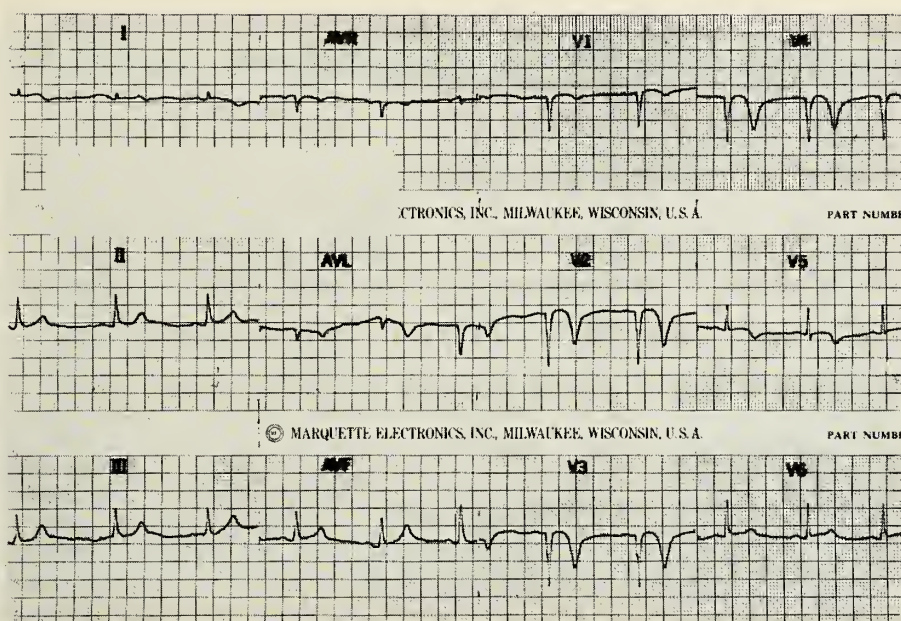
Leucocytes increase in smokers

A study of 4,264 men showed that the number of leucocytes is increased in smokers, notably in those who inhale. The increase is about 30 per cent for a heavy smoker who inhales, compared with a non-smoker. Investigation of a subgroup of 483 men of the same population confirmed this finding and revealed that the increase was in granulocytes, lymphocytes, and monocytes. The differential leucocytes-count showed no real change. (F. Corre et al.: "Smoking and Leucocyte-Counts," *The Lancet* Sept. 18, 1971, pgs. 632-634.)



ekg of the month

JOHN R. TOBIN, JR., M.D., M.S., RIMGAUDAS NEMICKAS, M.D.
AND PATRICK SCANLON, M.D./SECTION OF CARDIOLOGY,
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



A 50-year-old mechanic was seen in the emergency room complaining of retro-sternal pain radiating into both shoulders for the past 48 hours.

On examination he appeared to be diaphoretic. The blood pressure was 90/70. The lungs were clear. The heart was not enlarged, S_1 and S_2 were soft. At the apex there was a loud S_4 and a faint S_3 .

Questions: (One or more of the choices may be correct.)

- A. The electrocardiogram shows:
 1. Acute inferior wall myocardial infarction.
 2. Acute pericarditis.
 3. Quinidine effect.
 4. Recent anterior wall myocardial infarction.
 5. None of the above.
- B. The following clinical conclusions can be made:
 1. Left ventricular dysfunction is present.
 2. Digitalis may not be successful in improving the left ventricular failure.
 3. The usual digitalizing dose of digoxin should be given.
 4. Diuretics may be of value.
 5. All of the above.

(answer on page 82)

THE CHANGING FACE OF HEALTH CARE DELIVERY

"THE CHANGING FACE of Health Care Delivery" was examined by more than 400 physicians at the Illinois State Medical Society's Annual Leadership Conference on November 7, 1971 in Chicago.

Discussions on HMOs, neighborhood health centers, private firms which provide health care by contract and model cities health care programs were examined at the Conference and are published in abstract form on pages 38 to 55.

Cover photos and the pictures appearing on this page were taken at the Martin Luther King Neighborhood Health Center in Chicago. The Center is illustrative of *the changing face of health care delivery*, having replaced the old neighborhood doctor's office as well as the doctor himself, who spent endless hours making house calls only to return to an office bursting with people seeking his care.

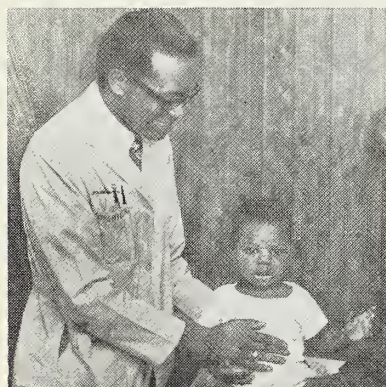
The Martin Luther King Health Center specializes in comprehensive medical services to children and adults in the target area (Boundaries are 16th Street, Fillmore, Central Park and Kedzie) and children living in the Lawndale area who have been referred by the Chicago Board of Health Infant Welfare station, school doctors or physicians in the North Lawndale Area.

The Health Center is licensed by the State of Illinois and City of Chicago, and approved by the Office of Economic Opportunity and the Children's Bureau of the Department of HEW.

A not-for-profit organization, health services may be paid through grants, commercial health insurances, public assistance, Medicare, private resources, state or federal programs and consumer's fee.

The staff of 193 persons provide services in the areas of dentistry, internal medicine, OB-GYN, pediatrics, social services, psychiatry and nutrition, as well as in such specializations as orthopedics, surgery and gastroenterology.

(Photos by Bob Campbell)



Neighborhood health centers and model cities Adjust your practice to their needs?

BY HARRY P. ELAM, M.D.

The health care of model cities

WHEN SPEAKING ABOUT Health Service as an institution you are talking about capital, structure and the quality and quantity of staff.

When the group representing the community approached the hospital about the advisability and availability of having a hospital as the umbrella back-up, there was one physician living in the area. He had been retired about 10 years. In the geographically defined area, there was no disagreement between physicians, since there were none. When we approached a dentist to attach to the neighborhood health center dental service, however, there were practicing dentists in the contiguous area. Some of them were of a younger age group. It became expedient to involve these men, through an advisory role, in the planning of the dental service. We were thus able to avoid some of the bitterness which has been evident in some health centers around the country.

Doctors are real people

One of the things to remember when trying to define a role or place is that physicians are real people, with some real roles in what I call the "sociology of medicine." One has to take into account the fact that this man also represents an organization, be it a solo practice, or another organization or group. You can avoid a lot of frustration and fighting if this is recognized.

I would like to talk about one of the things implied in this Leadership Conference-HMO. In this instance one is talking about cutting across a geographical boundary. It might step on a physician's or dentist's toes if one begins to move into this kind of structure without tak-

ing these professionals into account. When you don't listen to pros and cons, then you end-up with some rather nasty fights.

I would like to also talk about the concept of geographical location. In our particular area it was defined as a "mile-square area." What we do have, or did have, was roughly 85% of the people that would qualify. Here we have the concept of the neighborhood center being underwritten as a kind of prepaid insurance, with OEO picking up the tab.

Cost factors have to do with breaking this down into what is traditionally called ambulatory care. Medical service, doctors' fees, pharmacists' fees and laboratory work; that's one discussion. Then one has to cost account the other area—home visits and transportation. A third area would be items one would obtain specially for staff development, important for both career and public mobility.

One of the innovations at Mile Square was increasing reliance on paramedical persons in the field to help with the linkage between the center and the hospital, and what was happening to the person outside. Also, any hospital that's going to do a good job has to have a good house staff. The community paramedical person, must become the intern "of the movement" in such a setting. This kind of innovation frees the physician, so he is able to make home calls when appropriate. Usually these are on severely bedridden patients, particularly those with terminal illnesses or those so decompensated from their illness that they just can't make the trip. The comprehensiveness of this plan includes all the things you and I label as comprehensive. This includes the preventive aspect, the emer-

gency, specialty care, or the specialty clinics that one needs, and the back-up hospital. This implies a whole range of services one needs for either getting the person back from an episodic illness or help for maintaining him at a level of competency.

Regarding the question of adjusting "your" practice, I think we have to look at this as a mutual thing. When we move to these organizations of care, one has to take into account the local health practitioner, whether he be a dentist or physician, because if you do, some of the

bitterness can be avoided. Once you have eliminated that bitterness and come to common understanding, you can do an effective job.

HARRY P. ELAM, M.D., is the former medical director of the Mile Square Health Center, in Chicago. Dr. Elam presently holds positions in the Department of Pediatrics, Section of Ambulatory Care, Rush Presbyterian St. Luke's Medical Center, and in the Children's Division of Cook County Hospital. From 1962 to 1965, he accepted positions as lecturer and consultant at University of Ibadan, Ibadan, Nigeria. Dr. Elam's positions have been in the fields of pediatrics and psychology and he has authored a number of articles in these areas.

BY LEON REED, M.D.

Adjust your practice to their needs?

I CAME TODAY to talk about frustration. Model Cities came to town. It was seen by those who practice in the area certainly as a source of help. There was never any doubt that the medical group in private medicine did and certainly could use some support. Support and cooperation. In that frame-work we were prone to be cooperative, to listen and to join in the program.

As we experienced it, however, the neighborhood health center seemed to be far and more involved with recruiting people to what is called their enrollment than they were as a deliverer of health care. Recruitment became such an obsession that it was very hard to live within the frame-work of free enterprise. The health worker that we thought would go into the community to bring into the mainstream of medical care those individuals who were deprived and unsophisticated didn't happen. In fact, gross numbers seems to be the overwhelming trend. We found that the health workers in the community were enrolling people already being serviced. In the population we are discussing, the economy was overwhelmingly welfare, prone to instances where people were unable to afford medical care. The health center was simply vying for business.

Then there's a thing called an arrangement. An arrangement apparently is an agreement never put on paper. Never certified. Never actually official, but truly existent. First the concept

of enrollment, presumably, is to qualify an area to enroll. According to my source, certain groups were brought in by arrangement. This included the school board, athletic teams, and unhappily my own office staff. Enrollment of any one member of a family group automatically means all members of a family. Therefore, when all members of a football or track team are enrolled, large numbers, are enrolled.

No bond of ethics here

There was always a bond of ethics existing between the doctors who practice in the area. But the neighborhood health center did not feel bound by this. So you may find your friendly center across the street buying 50 radio spots a day, advertising in the paper, sending federally paid social workers into beauty shops, supermarkets and other places of public gathering, and saying "Come here, it is totally free and we furnish transportation." Leadership in the organization of centers take the attitude that all that is good in health care is back inside their own walls. They also seem to indicate that they are the community and that if you are unhappy you are against it. This, therefore, makes a burden and creates the schism that's truly unfortunate.

The concept of community meetings on the part of the centers, to decide what is good for the community, is in truth a good lie. If you can divide—if the consumer is divisible—it might

be divided into not organized, but organized and paid. In the not organized, the Model Cities group holds elections, and then each neighborhood incorporates organized groups. Often this is for very valid reasons. A large number of people, then, just happen to come to meetings. Those people are the Model Cities secretaries, the custodial staff, and other paid members, and they meet in perpetuity. They meet five, six, seven times a week. Those persons are from the organized section and are paid while they meet. Their meetings often last well into the evening. (Some people are paid and others get a half-day off.) The physician who tries to maintain private practice, will soon find himself exhausted and therefore no longer "interested."

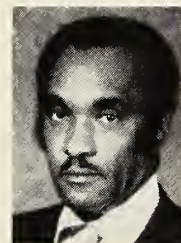
The potential is there, but . . .

There is no doubt that in the health care center concept there's a great deal of good that can be done. It's my impression that certainly the potential is there. It would appear that it

is not the intent of Model Cities to form the basic structure for an HMO. They are trying to produce in here a nucleus of a health care system that is both "foreign" and its nature basically unknown. Written approvals by some of the health centers are so eloquent, are so well written, and show such expertise they couldn't possibly have come from that center.

The citizens who are eventually demanding changes in medicine are either parroting or receiving these programs from somewhere else. It appears that the group establishing the programs is apparently programmed to give us an HMO of the nature of someone else's choosing. ◀

LEON REED, M.D., is an obstetrician-gynecologist in East St. Louis. A Diplomate of the American Board of Gynecology, Dr. Reed served his internship and residency at Homer G. Phillips Hospital in St. Louis.



15 HMO's in Illinois

How will they affect your practice?

BY MORTON W. ADLER, M.D.

The Carbondale "Experiment"

THE HISTORICAL DEVELOPMENT of the Carbondale plan began early in 1970 when a representative of the Community Affairs Department of Illinois Blue Cross-Blue Shield, who had been working with model cities, was invited to attend a meeting of Model Cities in Carbondale. The purpose of this meeting was to present information about a prepaid hospital-medical-surgical program which had begun in North Carolina and seemed worthy of further consideration by the Carbondale Model City community planners. Late in the summer of 1970, an application for a grant was made by Model Cities to the Department of Housing and Urban Development for funds to establish a similar program. Blue Cross-Blue Shield was nominated as the carrier to underwrite and administer it. In November 1970, approximately \$50,000 be-

came available to finance a prepaid health care program through August 31, 1971. Approval of Blue Cross-Blue Shield participation in an experimental program was given by the Board of Directors of Blue Cross and by the Board of Trustees of Blue Shield at their January meetings. This action was deemed appropriate by the boards in view of a resolution adopted by the House of Delegates of the American Medical Association at its annual meeting in June 1970 which states: "In seeking as its goal the highest quality and availability of patient care, the American Medical Association advocates factual investigation and *objective experimentation in new methods of delivery of health care*, while still maintaining faith and trust in the private practice of medicine and pride in its accomplishments." Following an intensive series of meet-

ings with all parties concerned in January and early February 1971, the program was launched on February 15. The Model City participants were those whose incomes are too high to make them eligible for public aid but too low to provide for a significant amount of medical and hospital care. From an eligible group of approximately 3,000, then, 52 families and 22 individuals were selected at random making a total of 223 people who could participate in the program. They were offered a dual choice, electing to receive their care either from the Carbondale Clinic under a capitation plan, or from individual physicians of their choice on a fee for service basis. Once having made this choice, however, no change could be made until the next enrollment period. It is interesting to note that—as might have been expected—in making their selections the families generally continued their previously established patterns of securing medical care. Those who customarily received care from the Clinic chose the capitation program and those who were served by personal physicians in solo practice chose the fee for service program. There are 33 physicians in Carbondale, 24 of whom practice at the Carbondale Clinic in 10 specialties. Representatives of the Clinic had previously expressed an interest in experimenting with a capitation prepayment plan on a small scale. Doctor's Hospital in Carbondale, a 120-bed facility serving the community and its officials, had agreed to cooperate by maintaining their charges for the duration of the program.

Scope of benefits

Under the plan, hospital benefits are provided for up to 120 days including care for tuberculosis, mental conditions, drug addiction and alcoholism. Hospital outpatient care includes emergency and diagnostic services such as laboratory tests, X-rays and electrocardiograms. Medical care includes benefits for in-patient hospital care, surgery, obstetrical care (without a waiting period) surgical assistance, consultations, newborn and well baby care, preventive care examinations, and office visits. Prescription drugs are provided as well as out of area benefits for emergencies and for consultations on referral by Carbondale physicians.

The "Experiment"

Somewhere along the line, this program acquired the unofficial title of "The Carbondale Experiment." Although everyone involved is learning a great deal about an alternative de-

livery system, it would be foolhardy to attempt to draw definite conclusions about the superiority of either of the dual choices. Furthermore, it is entirely incorrect to assume that Blue Cross-Blue Shield's cooperative effort in this program represents a belief that prepaid group practice is the preferred alternative to the traditional private fee for service practice. We are committed to becoming involved with any alternative prepayment mechanism which shows promise of improving on what we already have. Implicit in any of our future activities will be the guiding principle that free exercise of physician and consumer options and that the physicians' control of his professional activities be fully protected.

From our viewpoint, there should be little, if any, effect on the individual's practice except to perhaps increase his case load slightly because of the removal of the financial barrier which previously might have deterred some patients from seeking care which they felt they could not afford. Dr. Roy Phillip of the Carbondale Clinic has assured me that there has been no appreciable affect on their patient. To the best of my knowledge, no physician in this community has refused to care for these patients. It would be presumptuous, however, for me to attempt to reply specifically on behalf of the physicians of the community.

At the present time, additional funds have become available to continue a slightly expanded program through August 31, 1972. As of October 1, there are 116 contracts in force representing 350 participants. Based on the experience of the first six and one-half months of the program, we will refund approximately \$12,000 to Model Cities. This represents the difference between the premiums and actual benefit costs plus an eight percent administrative fee.

Since the concept of what constitutes an HMO is quite nebulous at present, it would be stretching the imagination to consider the Model City, The Carbondale Clinic or even Blue Cross-Blue Shield as an HMO. If one were to use the Kaiser Foundation Health Plan as a prototype of an HMO, then none of the three could be so classified although a few of the elements of an HMO are present to a very minimal degree.

Concluding remarks

In conclusion, this has been a very challenging experience for those of us who were involved

in this program and has shed much light on the nature of the problems of such an undertaking. It is hoped that the way has been paved a bit in working with physicians and their patients in providing health care options in the future. We anticipate working with the medical community and the public in this continuing atmosphere of mutual respect in responding to requests for assistance in developing pluralistic health care delivery mechanisms.

BY MERVIN SHALOWITZ, M.D.

Intergroup: Prepaid health services plan

I'M SURE THAT by now you are all familiar with Intergroup, a prepaid health services plan. We are non-profit and are incorporated under the laws of the State of Illinois. Intergroup came about because we in private practice felt that there was a need for alternative delivery and funding systems, and that these systems should be available to the practicing physicians today. We feel that the practicing physician should be the one who will design, operate, and be active in the implementation of this program.

Intergroup then is a culmination of almost 18 months of planning. It is the program that has been structured by private physicians with private industry with *no* federal funding. We have nothing to do with the federal government. I do not know whether we are an HMO. Nobody seems to know exactly what an HMO is. The government has not finally delineated the HMO concept, nor has an HMO been implemented at a governmental level except in the planning stages. However, if you speak of an HMO in a generic context with the ingredients of group practice, prepayment, voluntary enrollment, and preventive medical care as well as care for acute and chronic illnesses, we find that we have the generic meaning of HMO.

I do not like the term *Health Maintenance Organization*. I do not think that you can maintain anything over which you do not have control. I feel that you cannot legislate good health, but you may have the opportunity with the program such as I am outlining to practice more appropriately preventive medicine as well as treatment of acute and chronic illness. So with these

MORTON W. ADLER, M.D., is Vice-President and Medical Director of Blue Cross-Blue Shield. His former professional activities include private practice in Missouri, Illinois and Michigan, and as assistant medical director of the Cadillac Motor Division of General Motors. Dr. Adler holds membership in a number of medical societies and on the Medical Advisory Committee, Mayor's Commission on Human Resources.



few definitions in mind, let us discuss Intergroup's role as an alternative delivery and funding system.

The Intergroup plan

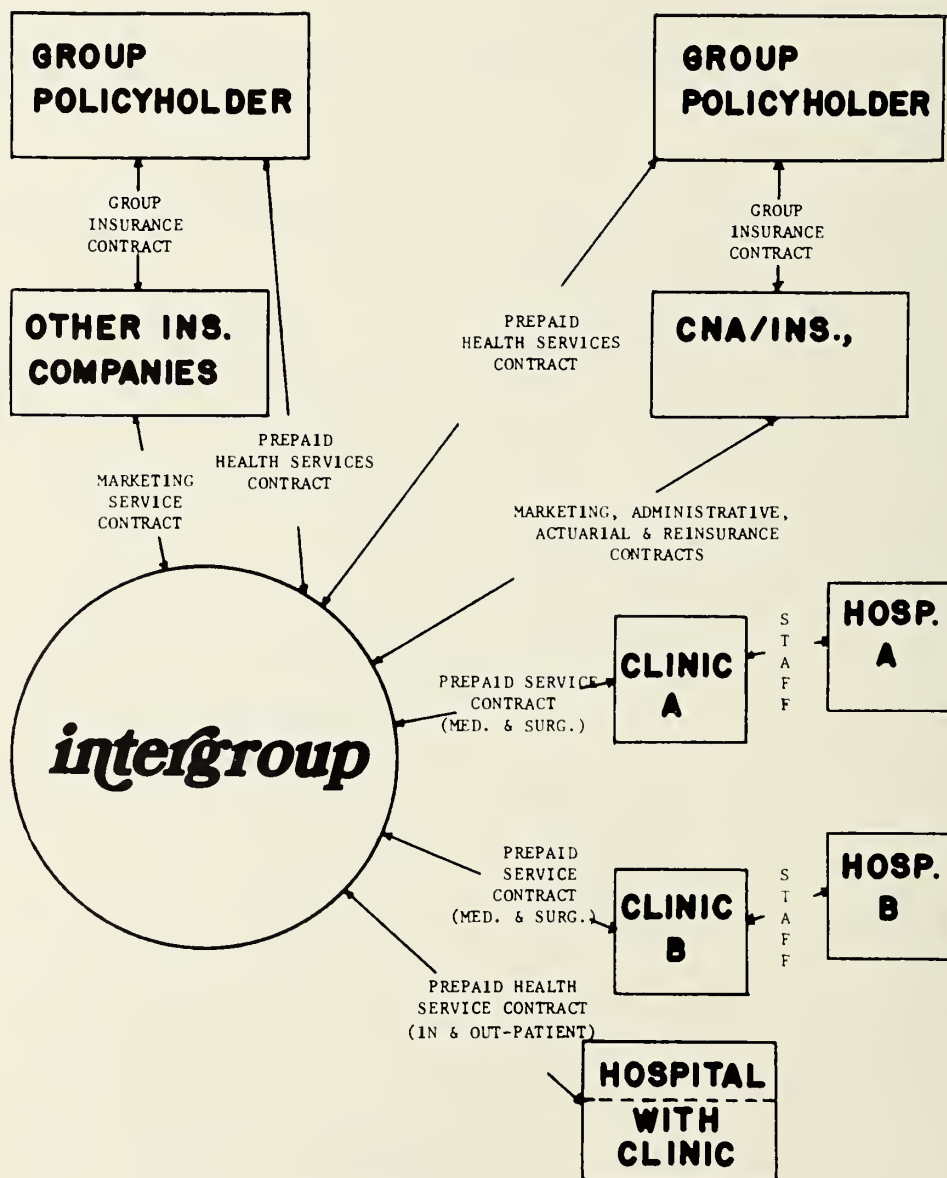
First of all, this plan is predicated upon the criteria we have just outlined for the delivery of care; that is, multi-specialty group practice. We are talking about a prepayment concept, and we are talking about emphasis on ambulatory care versus hospital-based care. I think it is unfortunate that we have all been brought up in medicine under a system where we have been taught that the only kind of appropriate so-called "good care" can only be delivered in the "ivory towers" of medical schools or of hospitals. This is not so. Over 80% of the health care in this country, not on a funding basis but on a delivery basis, is provided by ambulatory care. It is delivered in your office and in my office. I'm still in private practice and hope to continue so in addition to my administrative involvement in this program.

We have developed this plan with CNA/insurance and their two major subsidiaries, Continental Casualty Company and Continental Assurance Company. They have funded a feasibility study which has been completed. It is to their credit that they have funded the Intergroup non-profit corporation with a non-interest-bearing loan for reserves, and have also given us seed funds to begin administration and to implement the program.

Intergroup is a free-standing non-profit corporation which will contract with interested

groups to deliver health care. Figure 1 shows the relationship of Intergroup to free-standing clinics, hospital-based clinics, CNA/insurance, and other insurance carriers as they may participate. Intergroup is one part of a dual choice system. It is an optional plan that will be offered to interested subscribers initially on an enrollment basis—an option to their existing health insurance, whatever it may be. Marketing will start with CNA/insurance. We are, however, open to negotiation and will deliver our program to other commercial carriers as well as Blue Plans.

Initially, we will work on a regional basis in the States of Illinois and Indiana, and our future plans are to extend this regionally and ultimately, nationally. We feel there has to be a modular system available to physicians in which they have a vested interest and which they control to deliver this type of care. This concept is extremely important because to date there is no way for private physicians to involve themselves in prepay plans should they want to, in a free-standing clinic. We intend to bring health care to the people in the community. We feel that we should not fragment care, but bring it



CONTRACTUAL RELATIONSHIPS

to centers where patients can receive comprehensive care under one roof. These clinics do not have to meet all of the criteria for most major prepay plans elsewhere in this country, so we have open-ended the possibility of physician participation in a capitation program.

Of the group practice clinics in the Chicago area that we are currently negotiating with, all intend to continue their fee-for-service practice in care of patients in addition to implementing part of their practice in a prepay or capitation manner. There are very few plans that offer this option of complete freedom of a funding system to allow the physician to tailor his practice to his own needs both from a delivery and funding standpoint. Until Intergroup, I do not know of any other plan in the country that offers this option.

The prepay patient

The prepay patient will pay a cash registration fee of \$3 per out-patient visit, including a comprehensive annual physical examination, any intercurrent illness treatment, lab, or X-ray. Hospital visits are included in the basic capitation rate of the participating group. Any service that is delivered outside of normal office hours, regardless of where, which may be a house call, hospital emergency room care; or could be almost any other place, has a \$10 deductible per visit. There is also at the present time in the Intergroup plan a \$100 payment for pregnancy. Psychiatric service has a \$3 per visit deductible with a ten visit limit per each illness. This is a start. We hope in the future that funding will prove adequate to extend benefits. This is our starting point.

As far as patient-doctor relationship is concerned, any patient who chooses the Intergroup Plan (Intergroup will only be offered on a dual choice basis) will have the selection of a clinic in his or her geographic area. They may pick from among any of the clinics who will contract

with Intergroup. Within this clinic they may also select any of the staff physicians as their own personal physician, choosing among the primary care physicians those in family practice, internal medicine, pediatrics, obstetrics and gynecology, and possibly a surgeon. The selection of hospital, of course, will be determined upon the hospital staff availability of the clinic member. A patient does have a choice of clinics, and there are service overlaps among the clinics with whom we are currently negotiating. Any physician on any staff can be chosen as a participant's personal physician.

Some of the important factors that will determine the success of this, or any other plan that you may decide to come up with, whether it is a capitation program or an extension of fee-for-service type of option, will be, first of all the interest of the physician who is participating in the program, and, secondly, the acceptance by the public of the program. Here we get into the educational aspects of letting the people know what the program consists of so that they may make an educated choice.

How can you participate in this? I think I have answered that question. But when the concept of medical care as a *right*, and *not a privilege* was made known and embraced by the public, physicians have had to learn social science as well as biological science. We encourage your interest, your questions, and certainly your participation in this new program.

MERVIN SHALOWITZ, M.D., is medical director of Intergroup Prepaid Health Services, Inc., and director of North Suburban Clinic in Skokie. Dr. Shalowitz is also clinical professor of medicine at Loyola University Stritch School of Medicine, and a specialist certified by the American Board of Internal Medicine, as well as a fellow of the American College of Physicians. He is immediate past president of the Illinois Society of Internal Medicine.



By EMIL STAHLHUT

Group practice in Lincoln and a HMO

TWO YEARS AGO the Joint Conference Committee at Abraham Lincoln Memorial Hospital began discussing the developing shortage of physician services in the area. Hospital board

members frequently asked the question, "What can the hospital do to help in alleviating this problem?"

Many discussions and a few months later the

physicians on the committee volunteered further feelings on the subject. Individually, they did not think they could do more to resolve the problem. They were, indeed, busy people and each one on his own was doing about all that he could. There were no group practices in the area. They asked for an outside consultant to help study the problem, to moderate discussions, and to provide some fresh input.

The subject of basing a new physician group at the hospital had come up repeatedly and had seemed to be a natural solution to some of the problems faced by a number of the physicians in attempting to make more effective use of their time. How would this work? Was it a good idea? The general feeling was that if the physicians could work closely together with the entire in- and outpatient hospital process they might be able to make the existing physicians more effective through the use of pertinent mechanization and automation and the greater use of allied medical personnel. Furthermore, since new physicians are described as mostly group oriented today, it might be an ideal way to create a nucleus for attracting new physicians. The use of the hospital facilities, which represent a sizable investment not used to capacity, seemed like plain common sense. The hospital is comparatively new and the only one in the county.

A consultant was engaged in January, 1970. Over the next six months there were many meetings between the physicians and the consultant. There was a survey of community attitude, and a review of other physicians' and communities' experiences along similar lines. There were also reports on how others had attempted to respond to increasing health demands in the face of diminishing physician services.

It was recognized that the formation of a group from among solo physicians already in the community would be an experience different from what might usually occur in group formations. Instead of classmates and old buddies getting together and making up a group, physicians who have known each other over a period of years in their individual and solo practices now would be eyeing each other in a closer and different light. Though well acquainted they had never actually thought of being in the same group practice. Psychological examinations were therefore recommended and undertaken by the physicians to determine whether there was really a nucleus available who would be amenable to working together, socially, intellectually and professionally. On the basis of the outcome of the

tests there were at least seven candidates who were amenable and, furthermore, desirous of forming a group.

"What's an HMO?"

All of this took place before we had even heard the term "health maintenance organization" (HMO). It is true there had been some bantering around of the words "prepaid group practice," but that seemed foreign to us. Our physicians' and hospital's thinking had been zeroed in on the concept of "hospital based group practice."

Six months after completion of the consultant's feasibility study, discussion continued among the physicians about the entire idea of hospital based physician group practice. Needless to say, the problem of the insufficiency of supply of physician services in the area did not change. Various incidents demonstrating patient dissatisfactions due to the problem of the "too busy physicians" continued to drive this point home. Even though there was not unanimity as to what should be done, the idea that something had to be done was growing. Finally, in March 1971, ten physicians who felt strongly about the idea of hospital based group practice asked the hospital board for lease of space at the hospital. This, most certainly, was a landmark decision.

Simultaneously, throughout the nation there was increasing talk about the new health policy in Washington. What is a HMO? Do you think we should have one around Lincoln? These were questions that one heard from the various physicians and hospital board members. Planning was in progress regarding the possibilities of renovation of space at the hospital for the use of the physician group practice and the determination of the lease price the physicians would be asked to pay.

"Taking stock of their situation"

In April 1971, information became available about HEW grants which might be sought for design and development of a health maintenance organization. The intended physician group members and the hospital together began to take stock of their situation. The hospital had an intensive care unit which served both general medical and surgical, and cardiac cases; it operated a Medicare certified extended care; considerable emphasis had been placed on rehabilitation services over the years; there was an active hospital social service program; a Medicare certified home health service; an outpatient mental health and family counseling service; and

the hospital had a natural tendency to refer its specialty work to Springfield (30 miles away). All in all, didn't we have the natural elements that would make-up the comprehensive care which an HMO required? Furthermore, the county had recently voted a county health department which began organizing with a comprehensive scope. This could accomplish a valuable implementation of further preventive, health educational, and community nursing and environmental services.

These were the thoughts that were going through the physicians' and hospital trustees' minds at the time the application for the HMO planning grant was made. There was another aspect—Lincoln is in the center of Logan County and serves a large part of the county in addition to the adjacent parts of at least two other counties. Truly, there was interlacing with other centers 30 and 40 miles away, but the Lincoln area was somewhat of a well described area. As far as possible enrollment, there are a number of manufacturers with employees numbering from 200 to 600 as well as a state institution employing several thousand people. There is also a rural health group of 2,000 subscribers which presently brings Blue Cross and Blue Shield to its members.

The population of the area is about 40,000. Some have felt this to be too small to provide an adequate spread of risk. Newer concepts in terms of the HMO idea indicate that this may not be true, however. It is our hope that at least 20% of the target area will be enrollable during the first year.

There is still some question as to whether it will be possible to develop dental services at the onset to include these in the HMO package. The inavailability of sufficient dentists is a mammoth problem.

Our design study has not yet progressed to the point of deciding about the underwriting and marketing. It is not unlikely that an established carrier will be engaged to carry out these functions.

Effects on physician practice

What effect will this have on physician practice in the area? We certainly do not feel that the practice of physicians is going to be changed overnight. There will always be fee-for-service even with an active and aggressive HMO. The hospital based physicians will be handling many fee-for-service as well as the HMO beneficiaries. Other physicians who are not a part of the HMO—who may be in solo practice, or in other groups

—will be privileged to continue practicing in the hospital in their accustomed manner. It is hoped that they will experience a new sense of total solidarity and that they will realize benefits derived from the hospital based group at hand.

Lincoln is located 30 miles from the new Southern Illinois University Medical School in Springfield. Although this school has not yet received its first students, there have been many discussions about the possibilities of using the proposed hospital-based practice in Lincoln as a base for training senior medical students.

The Lincoln State School for retarded persons is currently using the hospital facility for surgical cases. After the group is functioning the Lincoln State School might contract with the medical group and hospital for all of its medical and surgical work. This will bring a new attraction in types of specialty care that are not readily seen in many hospital practices. Pediatrics, surgical subspecialties, retardation and aspects of psychiatry can certainly lend much to a fine educational package.

The Lincoln Medical Group is a group of motivated physicians who are imbued with the spirit of doing their very best for the improvement of the health of the area. They are not becoming hospital based for immediate financial gain. They have their own busy offices now. They see future advantages of professional development and better organized practices which will bring them, hopefully, the satisfactions they desire. Even though there has not always been unanimity in the course of events there has never been a lack of deep commitment on their part to move in the direction in which they are moving now. They are waiting to sign the lease and for the renovation of the premises to begin.

There are 21 active staff members who admit patients to the hospital at this time. The ten who will be going into the new group represent two-thirds of the practice in the area. It is their hope and the hope of all of those involved in the hospital family that the maximum cooperation can bring maximum benefits to our area citizens.

EMIL STAHLHUT has been the administrator of the Abraham Lincoln Memorial Hospital in Lincoln, Ill. since 1953. A Fellow of the American College of Hospital Administrators, Mr. Stahlhut is also a member of the Illinois Department of Public Health Hospital Licensing Board, and the Illinois Department of Children and Family Services State Advisory Council.



New hope for over-worked doctors and medically deprived areas

BY GENE M. GAERTNER, M.D.

General Medical Services LTD. Physicians-On-Call

General Medical Services, Ltd., better known as Physicians-On-Call, is a large group of physicians known primarily for their emergency department coverage in many hospitals around the State of Illinois. Presently, we provide Emergency Room coverage for some 12 hospitals throughout the state. However, our interest in health care delivery systems ranges far beyond emergency coverage.

Most physicians in larger metropolitan areas are already familiar with how high quality emergency department coverage can help relieve some of a busy physician's "after-hour" workload. I'd like to discuss how Physicians-On-Call has helped smaller communities get much needed medical coverage, using the Emergency Room as the Hub.

Overworked physician no myth

The concept of the overworked physician is no myth. From personal observations, I would estimate that the average working week of most practicing physicians is in the vicinity of 60 hours, spread over not less than a six-day week. In the smaller communities this workload is probably closer to 75 hours per week. Even if such a schedule is not exhausting, it certainly is restrictive, and along with a lack of back-up coverage probably the main deterrents in securing physicians for smaller communities.

Much effort has been expended in attempting to solve these problems. Small communities often develop doctor search committees that spend

many hours, and often many hundreds of dollars, attempting to acquaint doctors with the tremendous advantages of living in their city. They usually present a few snapshots of scenic surroundings, the local hospital (if there is one) and the high school. However, what they fail to present is the undeniable fact that the small town residents expect the physician to be available to them, 24-hours a day, seven days a week, 52 weeks a year. This is a pretty dismal prospect for a doctor considering small town practice.

Physicians-On-Call has given a great deal of thought and study to the problems of locating physicians in smaller communities, and giving them the advantage of an urban practice; that is, back-up coverage, guaranteed free time and scheduled working hours. From this thought and study evolved a project which I would like to explain in some detail.

Small town case reports

About a year ago Physicians-On-Call opened two small town clinics; one at Mt. Morris, Illinois, a town of 3000, and one at Durand, Illinois, a town of 1200. Both communities had been without a physician for greater than three years. Physicians-On-Call alternated some of its many physicians through these clinics. Some of the doctors spent a week, some a month, some several months, and currently a new Physicians-On-Call doctor has taken over the clinic for a projected two-year period. The physician spends four hours per day in each center.

About 15 miles from the Mt. Morris clinic, is Dixon, a city of 18,000 population. A few months ago, we contracted with the local hospital to provide emergency coverage, seven days per week, 24-hours per day, both in the Emergency Room and hospital proper. The hospital has 200 beds, (130 operating), and has just finished constructing an ultra modern seven bed ICU. Approximately 75% of the coverage afforded the hospital since the service began has been by Physicians-On-Call specialists—mostly internists with subspecialties in cardiology, pulmonary disease, nephrology and hematology.

These doctors, serving varied periods of time in the community hospital, cared for emergency problems and simultaneously provided specialty and sub-specialty consultations.

With this coverage established, a medical service corporation was formed and a recruitment program established through P-O-C to permanently locate in Dixon, a specialty group. Within the past two months, a board eligible general thoracic surgeon and an internist joined the Dixon group. These were the first physicians to move to Dixon in some eight years. These two, plus the physician covering the hospital is the equivalent of three new doctors in the community. We are presently seeking two more specialists for the group.

The key to the success of the recruitment is the 24-hour physician coverage in the local hospital. He is there to handle "after-hour" emergent and urgent calls and problems, both on an in-patient basis. The specialists can be reached only by him. This applies to weekends also. The patients from our small clinics are also directed to the doctor on call at the hospital by an answering service. This system provides back-up coverage and allows relatively scheduled working hours for the doctors involved. The clinic patients have a further plus in that the specialists located at Dixon offer consultant coverage to the two small town clinics, by each visiting the clinics one day per week to see specialty problems.

General Medical Services, Ltd., through an affiliate business corporation provides for handling of all billing, scheduling, and management problems, and the doctors are free to concentrate solely on the practice of medicine.

This system has benefitted all concerned. A small community hospital of 130 beds in a town of 18,000 has a physician physically present 24-hours a day (most unique) and two other physicians have now moved into the community. The local physicians in the area have more night and weekend time free, and some specialty services

now readily available, lessening the number of their patients that have to travel to distant medical centers. With the formation of a specialty group the hospital has an added source for growth and expansion of its services. The Intensive Care and Coronary Care Unit will soon be opened and Physicians-On-Call has undertaken the task of setting up and directing an in-service training program for the personnel selected to staff the unit.

I would like to cite other examples of how we have been able to render services to medically understaffed communities, and relief to the overworked physicians in these communities; all done by the simple expedient of setting up a large organization of physicians with a flexible scheduling program and modern transportation facilities. (Physicians-On-Call maintains its own aircraft with a full-time commercial pilot, and flies many of its physicians to the downstate communities from the Chicago area.)

It is obvious that whereas 24-hour emergency department coverage by a physician who remains physically present in the hospital is theoretically ideal, there are many areas in which the volume of patients would never support, financially, such an arrangement. The already overworked community physicians must take their turn "on call," usually by telephone, often relying on the nurse to diagnose the patients' problems. In the majority of cases, neither the doctors nor the hospital is happy with this type of coverage.

While the hospital may not be able to afford complete coverage, even a very small hospital can usually afford partial coverage, and we are now rendering just such a service to a hospital in a community of 6,000 population in North Central Illinois. Our physician is on duty from noon, Saturday to midnight, Sunday, a period of 36-hours. The work-time saved by the local physicians (six in number) by not having to make trips to and from the hospital to see "emergent and urgent" problems in the Emergency Room and in-house is enough that in essence this community has the equivalent of another physician in town. The local doctors have been most cooperative and supportive of this program and are delighted at the additional time afforded to their private lives.

Stepping-into a conflict

The last example I will refer to is unique, but illustrative, again of how our system can render emergency medical coverage at almost instant notice through cooperative efforts. Recently, a small community hospital had serious differences

with its staff doctors, to the point that the physicians were unable to practice in the hospital. This resulted in a suspension of physician services to the hospital. Within 24-hours of request one of our physicians was flown to the community and began around the clock coverage. We provided such service continuously for the six weeks it took to resolve the local conflict. Interestingly enough, the local physicians were grateful for the interim coverage, and one even worked with us elsewhere during the period of time the differences were unresolved. We retained the goodwill of the hospital, the local physicians, and the community, since it was in the best interest of all concerned that good medical services be maintained. The local physicians further requested that our services be continued on a week-end basis, and we have done so; 48-hours on a weekend from Saturday morning to Monday morning in a town of 3,200 population, in a 80 bed hospital. This again in essence, is the equivalent of another physician in town.

Summary

I have tried to illustrate how our group is striving to alleviate the problem of the over-worked physician. Our concepts are unique but

By JORDAN M. SCHER, M.D.

The Renaissance of the house call

THE HOUSE CALL is an institution which is probably even older than the physician himself. Perhaps it was invented by the old women who originally presided at births. . . . perhaps it was the mendicant sorcerers and witches passing through towns with their charms, spells and balms who started the practice. It is well known that Babylonian, Chaldean, and Assyrian physicians consulted as far as Egypt. Joseph paid one of the earliest recorded house calls when he attended Potiphar's wife (refusing her enticements, as good medical ethics would prescribe) and subsequently consulted with the Hyksos Pharaoh.

Despite Joseph's success with Pharaoh, physicians were not always well rewarded for their efforts, often punished for failure, and in general, not particularly highly regarded. For example, the code of Hammurabi prescribed fairly serious punishments for medical error. It is recorded that as Alexander the Great lay dying, he remarked, "I die by the help of too many physicians." Chronicles 2, 16 reports "Asa was diseased in his feet, until his disease was exceeding great; yet in his disease he sought not to the Lord, but to the physicians. And Asa slept with his fathers." . . . Another charge against doctors.

proven effective. The hypothesis that our country has a physician shortage deserves challenge. We believe the problem is maldistribution and poor utilization of physicians. We focus our efforts on proper utilization of and effective distribution of physicians, in a system that considers both the needs of a locale and the desires and needs of the doctor. In effect we are functioning as a form of group practice—an "extended group" practice, if you will, extending a varied program of physician services designed to successfully and immediately deal with the medical manpower shortage. We are not waiting for a proposed mass production of physicians, but we are trying to utilize the large number of concerned and available physicians currently willing to extend their services and expertise to areas most in need, in a time of need.

GENE M. GAERTNER, M.D., is president of Physicians-On-Call, of General Medical Services, LTD., in Lombard. Dr. Gaertner recently resigned from full-time attendance at the Veterans Administration Research Hospital, Renal Section-Hemodialysis Unit. His hospital appointments include Illinois Masonic Medical Center, Loretto Hospital and Northwestern University Medical School.



If you think you are busy, listen to the schedule of Maimonides, 12th century court physician who made house calls on the famous sultan of Cairo, Saladin, with whom the crusaders had so much trouble. "I dwell at Misr (Fostat) and the Sultan resides at Kahira (Cairo); these two places are two Sabbath days journey (about a mile and a half) distant from each other. My duties to the Sultan are very heavy. I'm obliged to visit him every day, early in the morning; and when he or his children, or any of the inmates of his harem, are indisposed, I dare not quit Kahira, but must stay during the greater part of the day in the palace. It also frequently happens that one or two of the royal officers fall sick, and I must attend to their healing. Hence, as a rule, I repair to Kahira very early in the day, and if nothing unusual happens, I do not return to Misr until the afternoon. Then I am almost dying with hunger. I find the antechamber filled with people, both Jews and Gentiles, nobles and common people, judges and bailiffs, friends and foes—a mixed multitude, who await the time of my return.

I dismount from my animal, wash my hands, go forth to my patients, and entreat them to bear

with me while I partake of some slight refreshment, the only meal I take in the 24 hours. Then I attend to my patients and write prescriptions for their various ailments. Patients go in and out until nightfall, and sometimes even, I solemnly assure you, until two hours and more in the night. I converse and prescribe for them while lying down from sheer fatigue, and when night falls, I am so exhausted that I can scarcely speak."

A few centuries later . . .

The house call business continued to boom for the next few centuries. Such people as Theophrastus Bombastus von Hohenheim, who gave us the word "bombast," and who was more commonly known as Paracelsus to his friends and enemies, spent many of his years as a wandering and obviously house-calling physician. House calling perhaps reached its zenith in the century of such illustrious physicians as Doctors Addison, Bright, Hodgkin, Osler, Jekyl, Morairity and Frankenstein.

Seriously though, there are many in Chicago who can remember the days of the horse-drawn physicians' carriages making their way from one end of our town to another. A recent survey by *Modern Medicine* reports that of 25,000 doctors polled throughout the country, 64% still make house calls, and 54% reported that they make at least five calls a month. Thirty-five per cent claimed to make 10 or more calls a month and 13% reported 25 or more calls a month. Nonetheless, the overall trend is toward fewer and fewer house calls. The older physicians seem to be the ones who still make the most calls. Younger physicians are less inclined to do so, many preferring to see patients in emergency rooms, if need be. There is considerably less house calling by day or night and 69% of those who responded, indicated that they were less inclined to make such calls today than five years ago. Most physicians seem uninclined to allow para-medical personnel to assume this task for them, with the possible exception of about half of the psychiatrists and internists.

A facet of health care delivery

Regardless of the statistics and the long and honorable tradition of housecalling, the very fact that we are discussing this problem as a part of the changing face of health care delivery indicates how vitally necessary a renewed interest in house calling is for today's busy, overworked physician. If we are to preserve medicine as a

part of the private sector of health care we must improve and up-grade our services and our image.

The Chicago Medical Society has for some time, as have other medical societies, maintained a list of those who will make calls on individuals who do not have a regular physician. However, what about the overworked physician who wants a few hours to himself on his day off, his evenings, or his week-ends? He either shares this burden with an associate, or he must assume it himself each day. There are some among us who seem to be sustained by the romance and obligation of perpetually being on call. Most of us, however, would rather spend time with our families, on the golf course, or in other ways than that of constant and un-remitting service to others.

Plagued with the disease of responsibility to others, physicians are painfully high in the areas of abuse of drugs and alcohol as well as the frequency of neurotic complaints and problems, emotional breakdowns, suicides and divorces. A number of recent studies have confirmed these facts. Perhaps we should all heed that old advice, "Physician, heal thyself," or a more modern and more useful version—"Physician, ease thyself," in other words, take it easy, relax. Be of more service to your patients, your family, yourself and all who know, depend on you or love you. Let's not be in the position of those among our patients and our colleagues for whom death is nature's way of telling us to slow down.

For the above reasons, and a number of others, Health Maintenance Systems has been formed in the Midwest to try to give physicians the respite, the needed professional support, and an additional answer to the community's legitimate demand for increased health care delivery services.

We provide physicians who will answer your calls, evaluate them, decide whether or not a house call is necessary, and if so, make that call for you. Our physicians are your agents, your assistants, your extension of your services to the community at large, and to your patients in particular. They are responsible to you, send a report to you within 24 hours, are available for consultation with you if you wish, and will refer appropriate cases to your hospital for admission on your service as the situation requires.

For their services you pay a monthly fee. The fee for the house call is paid by the patient at the time of the visit, so you are not burdened with problems of billing and other related mat-

ters. There is no question but that your prestige is enhanced as one who cares much more that your patients get the very best of service day or night, whether you are available or not. We have even had patients calling us to ask whether or not their physicians were subscribers to our service, as well as asking how they could induce their physicians to become subscribers.

Our physicians are drawn from young men who either do not wish to enter into full-time practice for one reason or another, are serving military duty, have recently entered practice, and are not yet fully occupied, or they are physicians who are in partial retirement. Some are physicians who prefer house calling to any other kind of practice. They are all fully licensed and insured. They must be men of proven responsibility, experienced and well recommended. They are selected after careful scrutiny and interviewing. They are also supervised by a panel of consultants. Our board is composed of some of the best respected physicians in the community, and nationally.

At the present time we have entered into negotiations with one of the largest and fastest growing laboratory services in the country to work with them in amplifying their efforts as well as ours on your behalf. It is our expectation that beginning January 1, 1972, we will be extending our services to a four-state area in the Midwest as well as a main eastern city in the south. If current plans continue to unfold as they now seem to be doing, it is our intention to become a public company in the not-too-distant-future with the development of other kinds of health care delivery services and activities to help improve the image and the face of medicine today.

Today's health needs require a physician to devote more attention to his patients than ever before. However, physicians are only human beings like the rest of society, despite their inner pressures to be all things to all people all the time and in the best possible manner. Such

devotion is highly commendable, but also highly dangerous for the physician as a human being and as a servant to his patients. He only gives so much of himself without stretching himself beyond the point of maximum efficiency. He must learn to give himself and his family the break he always commends to his patients lest he himself become a patient too. Health Maintenance Systems intends to provide that "extra arm," "extra leg," and "extra brain," as well as those extra hours we all require if we are to enjoy our lives, as well as serve our fellow man. Future shock has come and gone for the physician long ago in his history. The physician must today deal with future shock squared. Neither Alvin Tofler, nor Marshall McLuhan, nor any other of our current pundits has been able to tell us how to solve the riddle of accelerating health care needs and a much slower rate of increasing health care services.

Health care delivery is going to require an intensity of inventiveness and ingenuity, maximum utilization of available personnel, facilities, and services, and above all a desire to innovate and experiment in bringing the best possible care to every segment of American society. To this end, Health Maintenance Systems, as well as a number of other health care services, are devoting their best efforts. ◀

JORDAN M. SCHER, M.D., is president of Health Maintenance Systems, Inc., in Chicago, director of the Chicago Psychiatric Foundation and Ontoanalytic Institute and the National Council on Drug Abuse, and editor of *Existential Psychiatry*. Dr. Scher is on the staffs of Fairview and Weiss Memorial Hospitals in Chicago and chairman of the Committee on Delinquency and Youth Crime of the Sheriff's office, and a number of medical journals. A Diplomate of the American Board of Neurology and Psychiatry, and Board Eligible to the American Board of Internal Medicine. Dr. Scher has also authored numerous papers on psychiatry and a book, *THEORIES OF THE MIND*.



BY MARJORIE SMITH, M.D.

Contract emergency service system

THE CONTRACT EMERGENCY service system has been in existence now for about 12 years. The service is patterned upon the out-

standing group from Alexandria, Virginia, a small format that began a service. The next major group was constituted in Pontiac, Michi-

gan. I'm sure you are familiar with the Pontiac and Alexandria plans.

The organization with which I work, MESA, has about a seven-year history. It had been a partnership corporation with many doctor members. We have both full and part-time physicians. We've had a hospital board and our own board, we have purchased private loan services, and we are now on our own for billing services and computer. In addition, we do all our own administrative work. Twenty-six of the 45 physicians are Board-certified or eligible in one or more specialties, and 12 are full-time in emergency work. We believe that the best of private medicine and the best of private enterprise provide far better medical care, and faster care for less money than any other available methods.

The emergency service problem has been with us and will remain so. It is nothing more when you contract service than simply rearranging the elements to try to achieve more efficiency in the private practice system for the care of patients. It does not, by itself, raise the quality of care. That can only be accomplished by individual physicians who are motivated to raise the quality of their individual performances. The change in efficiency is probably the single most important element in raising that quality. Everyone is motivated to do a better job. In medicine, all physicians are naturally this way.

How the contract system works

Contract Emergency Services does provide an extra motivation for doing that, as far as the individual is concerned. The emergency physician has just one chance to see the patient. He has no second try; he has no appreciable lapse-time to think over problems. Another doctor will soon see the same patient for the same problem and a follow-up visit, and therefore will peer review each case with a very personal concern for the outcome of the patient. This type of external motivation is rather forceful in creating emergency care services for an area.

In order for a contract group to support itself on fees from the patients it serves, the patient load must be upwards of 20,000 visits a year. And emergency service of that size is strenuous, heavy work and not very conducive to a relaxed atmosphere. It requires physicians' stamina and a steady flow of decision making, often under quite harassed conditions. One of the major abilities needed by physicians doing the work is to be able to organize the activities of those

around you—both medical and non-medical people—in the emergency situation. Also required is a change in orientation, from the desire to make a clear-cut diagnosis to managing an emergency situation.

The goal of managing an emergency situation is to stop the down-hill course a patient has, or thinks he has, from the moment he arrives in the emergency department. Afterwards, there's time to summarize, and begin to reverse a situation for the patient and his family. Thereafter, a good deal of communication is required, both to the patient and the follow-up physician, to get enough accurate data so that progress can be continued without back-sliding. The satisfaction of warm continued patient relationships is generally absent for the emergency physician as is the satisfaction of seeing a healed and favorable result. Taking their place are the criticisms and recriminations for errors or incompleteness as well as patients' resentments for the impersonalness of the average 10 to 12 minute encounter with an unknown physician. Most physicians who go into this work are peculiarly capable of establishing a rapid and clear rapport with a patient, and enjoy doing so. The result—the patient usually does not leave the unit feeling indignant.

Thirty contract groups in Illinois

There are at least 30 contract groups in Illinois at the present time; some of these contracts are written and some are not. There will be increasing numbers of these groups and they will increase just about as rapidly as physicians will decide to put some or all of their time into this kind of work. The growth of this smaller practice would be limited only by the number of such physicians who are willing and able to do this.

The Illinois emergency service plans will establish additional heavy load stations in the future. In order to organize a group one must usually find a dedicated physician who will give up most of his practice for awhile and set about the job. He'd better be able to afford the luxury. Successfully functioning groups, however, can often be established on the Pontiac type plan without having to give-up totally the private practice, which most of the physicians do have.

The organizer generally has a tough job in gaining agreements with the Hospital Board of Trustees, the administration, the nursing service and medical staff, the patients, and often the community acceptance of the hospitals in the area in which they find the work. The agree-

ments themselves must include all details of staffing, referral record keeping and remuneration. Billing by the hospital is cheaper if the group did the job itself. However, in most groups across the country, including Illinois, for the hospitals to do the billing the physicians finally gravitate to a system in which they have the jurisdiction over the billing operation. One of the great fruits of this is that the feedback from patients usually comes with the payment of the bill. Therefore, information comes quickly through the billing operation, to physicians, regarding patient dissatisfaction. We are able to get back to the patient directly and explain any misunderstanding, or talk to the follow-up physician and see what the situation is all about.

The emergency physician seeing the patient becomes the legally responsible physician for care of the patient at that time, regardless of the previous ways in which the patient and his physician have behaved. Much education of patients and physicians is required in making that adjustment. It may require two years for understanding to permeate all levels. Remuneration to the physician should be maintained at least one-third more than you would at first suspect. The kinds of hours served are the basic reason.

Pluses and minuses in the system

Let's look at the real problem. There are three eight-hour shifts in a day. There are 21 eight-hour shifts in a week, to be covered on any 24-hour service. There are five periods that you might call desirable working hours, 16 of the eight-hour shifts are undesirable working hours. When the service exceeds 25,000 visits a year, there are 28 such eight-hour shifts, if you are going to spend 10 or 12 minutes with a patient. Five are still desirable, 23 are now undesirable. Evenings, nights and weekend hours double as the service gets heavier, since it is the late shift that contains the bulk of patients, and pays the way for the other shifts of the day. So any way you space it, no one wants to work the 6 p.m. to 6 a.m. morning hours all the time, or all weekends and holidays. I did have a hospital administrator say it would be nice to have the same doctor on every evening from 3 to 11 p.m. at night. That would be just fine providing you could have the same doctor seven

days a week, 52-weeks a year. Of course, this is kind of ridiculous.

To balance all the negatives, however, time arrangements which give consecutive free time are quite helpful to the formation and viability of one of these plans. Neither money alone, nor time alone, as a bonus will suffice. But the two together will constitute a possibility for a very excellent form of life. Many in the group will be working an 80-hour week, and then are off a week. There has been very little illness among the groups functioning in this manner. This requires the absolute full-time emergency physician, and the acquisition of such individuals has been quite gradual.

The ideal physician for the work is one who enjoys problem solving, excitement and variability, and has fine communication skills. You need someone with a good deal of experience in surgery and in surgical diagnosis, but also an interest in medicine, pediatrics and psychology. It is more natural for the surgeon to handle medical problems for the first half-hour than it is for an intern to handle the first half-hour of two or three multiple injury victims from a nasty accident.

These are the challenges. The biggest problems in developing contract emergency service in a hospital is getting physicians to behave logically with respect to the necessity of serving their customers' demands 24-hours a day. The fear of patient's ill feeling is sometimes a neurosis the overworked physician has. A persistent atmosphere about fee splitting alters efficient referral systems.

In spite of all of these things, when a successful system has been organized recruits are great. There is better productivity for the physicians in private practice in the area, and they have a good local attendant available for them 24-hours a day. There is a better productivity for the physician rendering the emergency care, and preservation of the best elements of the private fee-for-service practice as far as patient-doctor relationships are concerned. There's also ultimately a reduced adult care-cost in the community in the long run. ◀

MARJORIE SMITH, M.D., is a member of the Illinois Chapter of The American College of Emergency Physicians, and on the staff of Grant Hospital in Chicago.

By ROBERT W. BLUMSTEIN, M.D.

Comprehensive Medical Associates

COMPREHENSIVE MEDICAL ASSOCIATES began as a multispecialty group in the office of a general practitioner, John L. Schmidt, M.D., in the West Side (East Garfield Park) Ghetto area of Chicago. Dr. Schmidt sought to surround himself with specialists in internal medicine, obstetrics and gynecology, general surgery, pediatrics and ENT. The 11 physician-group formed found itself capable of reproducing the multispecialty group practice concept in two additional inner city areas where availability of medical care was inadequate. The group has grown in number over the past few years, operating three medical centers; and simultaneously dentistry, optometry, podiatry and adequate nursing services were incorporated into each of the medical centers.

All of the physicians in the group joined the staff of Illinois Masonic Hospital and linkages were created for patient care by referral in ophthalmology, urology, psychiatry, cardiology and cardio-vascular surgery, filling the gaps previously present in the multispecialty group.

By adding the option of pre-paid comprehen-

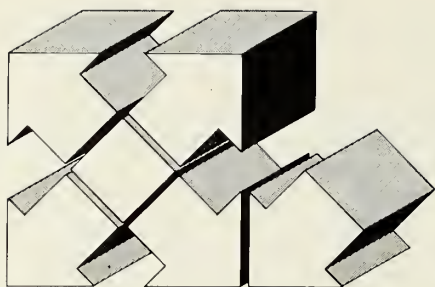
sive medical care as a dual choice to the above described formula the concept of CMA-HMO, Inc. grew. The concept of a physician controlled, non-hospital based (hospital affiliated) HMO, offering the patient dual choice between: 1) *Pre-paid* and 2) *fee-for-service* care, while offering the physician dual choice between: 1) *Salary plus incentive bonus* and 2) *fee-for-service* remuneration is our answer to the current challenge of providing high quality comprehensive medical care for everyone in the urban population. ◀

ROBERT W. BLUMSTEIN, M.D., is president and medical coordinator of CMA-HMO, Inc. (Comprehensive Medical Associates-Health Maintenance Organization), and on the staffs of Loretto and Illinois Masonic Hospitals. Dr. Blumstein is a Diplomate of the National Board of Medical Examiners and of the American Board of Obstetricians and Gynecologists.



A friend for the dying man

Being confronted by a patient with a fatal illness is always an unpleasant part of our work. I think that all concerned subconsciously feel guilty because they can do so little to help, and the whole issue may well be evaded. A farmer came to see me with a large spleen and I referred him to the hospital, where the organ was removed. He was a jolly fellow and a very good patient. He cracked jokes with all, and was one of the most popular patients in the ward. Four years later I saw him again with pyrexia of unknown origin, and once more he went into the hospital. He was found to be in the terminal stages of leukemia. He felt desperately ill and all his old sparkle had gone. He lay in bed almost completely ignored by the staff. Sadly he told his wife, "I know they can do nothing for me this time. They do not even speak to me." I am sure that the cruelty was unintentional. In family practice this could hardly arise, as the G.P. who visits is responsible on his own for what goes on; he cannot evade the problem. In the hospital the responsibility can easily be shelved, in that each member of the staff thinks that someone else will do it, so that it never gets done at all; thus no one befriends the dying man when he most needs to be befriended. (C. A. H. Watts.: "The Hot Line," *Brit. Med. J.*, Aug. 14, 1971, pgs. 419-421.)



trauma center

BY DAVID R. BOYD, M.D.C.M., KENNETH D. MAINS, USN/FLT RES,
AND BRUCE A. FLASHNER, M.D.

Status report:

Illinois statewide trauma care system

ON JANUARY 23, 1971 Governor Richard B. Ogilvie introduced a Plan for the Development of a Statewide System of Trauma Centers in Illinois. Later, on April 1, in a special message on health care,¹ Governor Ogilvie discussed the future development of some 40 specialized centers for the care of the critically injured patient to be designated throughout the state. These centers would be specially staffed and equipped to handle the complex needs of the critically injured patient. There would be an appropriation from the State Legislature matched by and reimbursed from National Highway Traffic Safety Administration funds, which would total approximately 1.2 million dollars and provide the basic components for a network of interlocking trauma care centers.

In the March issue of this journal, "The Critically Injured Patient: A Plan for the Organization of Statewide Trauma Facilities" was presented.² The three echelons of care to be established were called Local, Areawide, and Regional Trauma Centers. A book published by the Illinois Department of Public Health described the plan in more detail and was titled *THE CRITICALLY INJURED PATIENT—CONCEPT AND THE ILLINOIS STATEWIDE PLAN FOR TRAUMA CENTERS*.³ This plan originated in the Office of the Comprehensive Health Planning Agency and was implemented by the new Division of Emergency Medical Services and Highway Safety of the Illinois Department of Public Health.

Advisory to this program is the Governor's Advisory Committee for the Critically Injured Patient which includes the Executive, Regionalization, Trauma Management, Training and Edu-

cation, Transportation and Communication, and Epidemiology Subcommittees. Also, a large and growing number of clinical and special consultants from the professional and lay community are represented on this advisory body.

The basic developmental plan was to designate and establish some nine Regional Trauma Centers across the State of Illinois. These would be situated within the Governor's Regionalization Districts and utilize the growing university health education potential of these regions.⁴ During the spring of 1971, those communities which were to develop university educational systems were to be introduced into the Trauma Care Program. Initial acceptance by these communities set the groundwork for early working relationships with the Division of Emergency Medical Services and Highway Safety and local planning agencies.

Basic to the trauma care plan was the consolidation of professional services within a given community. It was thought that most of the essential professional resources existed within Illinois, especially in the larger urban areas. Designation of one Trauma Center in a community could provide optimal care for the critically injured accident victims in that area. Regional Trauma Centers will have adequate medical staffing and are equipped to handle almost any traumatic emergency. All Regional Centers are located in university health education centers without additional expense or the need for large building programs. In many of the centers, however, the on-going extension programs were incorporated into the general scheme. These Centers have begun the coordination of advanced communications and transportation networks necessary to unify and upgrade emergency health care across the state.

At the present time there are ten Regional Centers operating (listed below).

These facilities were chosen because of their educational resources, special care capability,

and growth potential. Where a university hospital system was to utilize more than one hospital within a community, the community planning agency was asked to designate the center with the care capability most consistent with the Statewide Plan. When only one university hospital had been established within a community, designation was accomplished by direct negotiation.

So far, the nine Regional (geographic) Trauma Centers and two "Special" Regional Centers have been integrated into the Statewide System. The Special Regional Centers at the Children's Memorial Hospital and the Spinal Cord Injuries Center of the Wesley-Passavant-McGaw Complex are intended to serve the entire state for special clinical problems.

During the first six months of operations, the improved care for the critically injured patient has been evidenced by the increasing numbers of referrals from outlying hospitals and communities into the Regional Centers. At these Centers, special educational programs have been

Table 1

Region	Community	Hospital	Affiliation
I A	Rockford	St. Anthony Hospital	University of Illinois
I B	Peoria	St. Francis Hospital	University of Illinois
II	Chicago	Cook County Hospital	University of Illinois
II	Chicago	Billings Hospital*	University of Chicago
II	Evanston	Evanston Hospital	Northwestern University
II	Maywood	Loyola Medical Center	Loyola University
III A	Springfield	St. John's Hospital	Southern Illinois University
III B	Champaign-Urbana	Burnham City Hospital	University of Illinois
V	Carbondale	Doctors Memorial Hospital	Southern Illinois University

Two "Special" Regional Centers have been designated and have begun serving the entire State. These are:

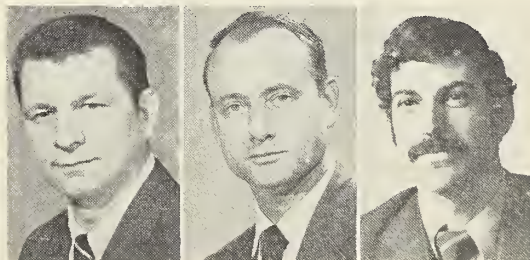
Region	Community	Hospital	Affiliation
II	Chicago	Children's Memorial Hospital	Northwestern University
II	Chicago	Northwestern University Spinal Cord Injury Center	Northwestern University

*** To Be Designated**

DAVID R. BOYD, M.D.C.M., (left) is chief of the Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health, and assistant professor of surgery at the Abraham Lincoln School of Medicine.

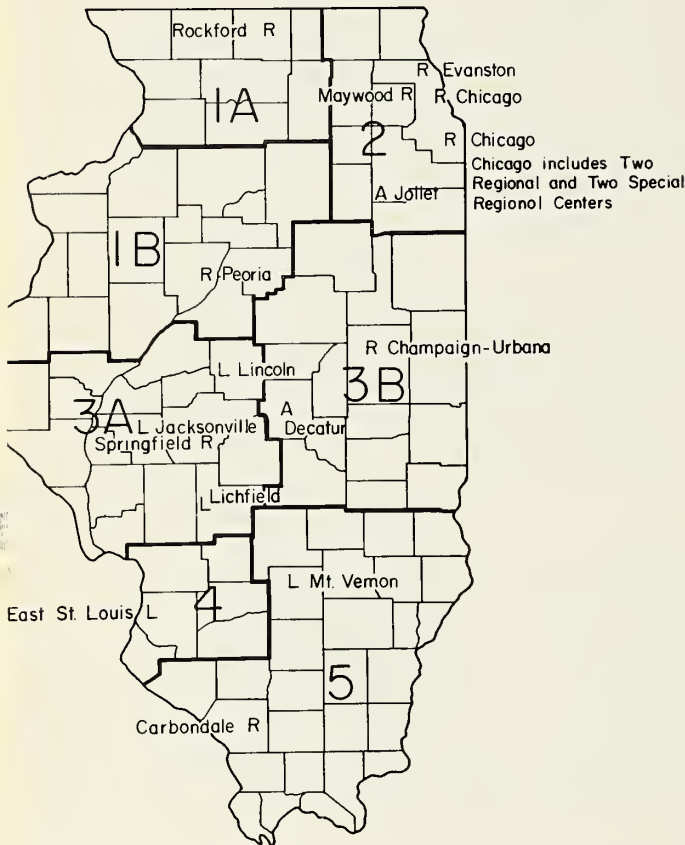
KENNETH D. MAINS (center) is administrator of the Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health. Mr. Mains joined IDPH in June, 1971, after serving 24 years in the U.S. Navy where he gained experience in medical evacuation of the injured.

BRUCE A. FLASHNER, M.D., (right) is deputy director of the Illinois Department of Public Health and medical director of the Illinois Department of Public Aid. He is also an assistant professor of health care planning at Southern Illinois University School of Medicine.



Status report : trauma system

STATE OF ILLINOIS ADMINISTRATIVE REGIONS AND TRAUMA CENTER LOCATIONS



developed and basic research projects have been continued. The Regional Trauma Centers are the central hubs within their respective region for specialty care backup, educational programs and research. They also serve as communications and transportation centers for their respective regions.

Areawide Centers

The Illinois Statewide Program has progressed to develop several Local and Areawide Trauma

Centers. There are two Areawide Trauma Centers designated and soon to become operational. These are located in the larger communities across the state, where expert medical resources exist outside of university educational centers.

Table 2		
Region	Community	Hospital
II	Joliet	St. Joseph's Hospital
III B	Decatur	Decatur Memorial Hospital

The Areawide Centers will, by their sophisticated care capability, be able to handle a great majority (probably over 95%) of the trauma patients admitted. They will also support, as do the Regional Centers, those local care facilities closest to them. The Areawide Centers, by virtue of not being part of a university health education system, are not obligated to maintain advanced professional (surgical) training programs. However, basic allied health and other professional educational programs will be developed in these centers.

Local Centers

Local Trauma Centers are also coming into the system. These centers are providing basic life-saving resuscitation to the critically injured. Physicians and surgeons in these centers provide the care that is consistent with their resources. These same physicians decide when transfer to an advanced Areawide or Regional Center is necessary for optimal continued care. To date, four local care centers have been designated and have begun operations.

This regional planning is based on providing fixed reference points for trauma patient transportation and medical care. Where bi-state planning and resource utilization have been necessary, this has been developed.

Almost every community and area of the state has been visited. Negotiations have been initiated with the professional and Health Planning Council Agency in these areas. This includes the city of Chicago and downstate Illinois. It is the

Table 3		
Region	Community	Hospital
III A	Litchfield	St. Francis Hospital
III A	Lincoln	Abraham Lincoln Memorial Hospital
III A	Jacksonville	Passavant Memorial Hospital
IV	East St. Louis	St. Mary's Hospital

program plan to develop the Trauma Center Network as soon as possible so that other elements of the total program can be activated.

Trauma Coordinators

The Illinois Statewide Plan has identified several new clinical specialists, one of which is the Trauma Coordinator. This new job title has been won by experienced military-trained medical personnel who, after eight, ten and sometimes twenty or more years of casualty experience, are becoming an integral part of the system. These emergency health experts are employed by the Department of Public Health and located at the Trauma Centers to assist in the many administrative and managerial aspects of the program. Trauma Coordinators are responsible for the ongoing data collection of the Trauma Registry. They are establishing in their areas the basic training courses for ambulance technicians. By working with hospital medical chiefs of staff, trauma surgeons, and administrators they are developing better liaison with the community including ambulance, rescue, and law enforcement personnel. These professionals have been instrumental in developing the Statewide program at the community level and have made significant contributions to the care of the critically injured by improving the organization of the Illinois Emergency Medical Care System.

The Critical Injury Index

To enable law enforcement officers and emergency attendants to better define those accident victims with critical injuries, a descriptive scale has been developed. This is a list of the ten most important features of serious injuries, which are described in non-medical terms. Law enforcement officers are usually the first persons at the accident scene and can, by quickly identifying any of the abnormalities listed on the Critical Injuries Index (see below), determine the necessity of transportation of the patient to a Trauma Center. Any attendant can describe these findings over a two-way radio system to a professional at the trauma receiving center. These are descriptions of the attendants' findings and are not to be misconstrued as diagnoses. Most observations can be made by direct visual means and by palpation. Blood pressure is not included in this index as many of those persons first at the scene do not have the capability of obtaining one. The acknowledgment and early activities are key when the radio system is intact and will speed up the process.

The Critical Injury Index has been printed on pocket size cards (4 in. x 4 in.) for easy access in times of emergency. On the back of this card is a list of the Regional Emergency Dialing Numbers (RED NUMBERS). Each telephone number when called, will alert the closest Trauma Center of a serious accident in the vicinity and allow for early preparation for possible admissions.

Table 4
Critical Injury Index

System:	Abnormal	Severely Abnormal
1. Airway	obstructed, partially by foreign object	obstructed, completely by injury
2. Breathing	shallow or uneven	labored or undetectable
3. Respirations	24-36 per minute	below 16, above 40 per minute
4. Bleeding	minor, controllable by external pressure	massive, uncontrollable by simple pressure
5. Pulse	90-120 per minute	irregular or none, below 60 or above 120 per minute
6. Wounds	superficial multiple lacerations, or abrasions	major, deep, or with loss of body parts
7. Fractures	deformed extremity, stable, closed	bone exposed, unstable open
8. Extremity sensation	any change in feeling, tingling, burning	loss of feeling (anesthetic)
9. Extremity movement	any limitation of voluntary motion, or weakness	loss of functions (paralyzed)

Identify the most severe category and report in the order as listed (that is airway-obstructed with vomit, breathing-uneven, mental state-confused, etc.) Identify bleeding location, seriousness, and controllable; fracture sites, and amputation or near amputations.

Status report : trauma system

Educational Programs

Special programs for trauma care, e.g. surgical grand rounds, symposium, and conferences for physicians, surgeons, and medical students are being developed statewide. The Trauma Nurse Intensive Course at the Cook County Hospital Trauma Unit has finished its second session and has provided upgrading postgraduate training for nurses from across the state. These nurses have returned to their centers and will improve accident patient care in these hospitals. Within the next year the Trauma Nurse Training Program will be developed in Regional Centers across the state.

Ambulance attendant training programs are being initiated. The educational materials for the Emergency Medical Technicians Ambulance (E.M.T.), the Department of Transportation Recommended Course, have been assembled in the Regional Centers.^{5,6,7} These programs will be given periodically in the Regional Centers.

Surgical Grand Rounds for Trauma Care have been held at the Abraham Lincoln School of Medicine, the Evanston Hospital, the St. John's Hospital in Springfield, and the St. Francis Hospital in Peoria. An Invitational Trauma Day was sponsored by the Children's Memorial Trauma Center. Interest developed by these sessions has provided a local forum and educational experience for the entire trauma center professional and allied health staff. These programs have been well attended by the hospital staff and visitors from across the state. Proceedings of these Grand Rounds will later be published in the "Trauma Center" Section of this journal.

Nursing

The Trauma Nurse Program has so far been conducted at the Cook County Hospital Trauma Center. The beneficial effects of this program are evidenced by the fact that graduation test scores have improved significantly. Nurses have been trained in the latest techniques of resuscitation and management of the critically injured patient. On returning to their parent hospitals, they have helped to improve the quality of care there and throughout the region. The enthusiasm for the course by these graduate nurses has been outstanding. The large number of trauma patients at the Regional Centers provides an excellent training resource. The Trauma Specialist has been developed to upgrade the nursing personnel presently working in emergency rooms and trauma centers. Thus, a spe-

cial training program of four to six weeks has been developed at the Cook County Hospital and will soon be operational at Loyola University Medical Center, Evanston Hospital, and St. Francis Hospital in Peoria. It is planned that all regional centers will develop this program for trauma nursing.

Ambulance program

The E.M.T.-Ambulance program will provide the basic course necessary for developing an adequate uniform base line performance capability for ambulance attendants. The anticipated passage of a statewide ambulance service law will require this basic E.M.T. course as a mandatory requirement of operation.

The E.M.T.-Ambulance training program uses the Dunlap Associates Course which is modeled after the American College of Surgeons Ambulance Training Program. This 82-hour course is being developed at the Trauma Centers to fill the obvious void in obtaining qualified personnel for ambulance work. These training programs have been developed in close cooperation with certain community colleges. It is planned that as this program is developed and after proper training and retraining, the reservoir of ambulance attendants will expand as young men and women from the community college become trained. This will not only improve the transportation care system in the community but will also provide enhanced resources of ambulance technicians as trained personnel will be able to apply for entrance into the National Registry of E.M.T.-Ambulance.⁸ This program will also make the passage of pending ambulance legislation easier and will provide the necessary upgrading of services throughout the state.

These training programs and other special postdoctoral educational programs have been provided in various institutions and these have been publicized through the trauma system network and fostered and supported by the Division of Emergency Medical Services and Highway Safety. It is this total educational approach that has been the hallmark of the Illinois Statewide System and is basic to the improvement of care for the critically injured even after regionalization and consolidation of services have been implemented.

The Trauma Center Newsletter

The first two editions of the *Newsletter* were distributed in November and December. This

monthly report is being sent to all surgeons and emergency room physicians and nurses in Illinois. Over 8,000 copies have been sent in response to a mailing list call by the Division of Emergency Medical Services and Highway Safety.

Topics discussed have been: (1) Trauma Program Status Reports; (2) Implied Consent Legislation; (3) Ambulance Service Information; (4) Regionalization; (5) Critical Injury Index; (6) Renal Transplantation; (7) Blood Procurement; and (8) Educational Events.

The Ambulance Problem

The Division of Emergency Medical Services and Highway Safety is developing an Ambulance Survey and Educational-Informational Program to better inform those concerned with ambulance services. Local ambulance funding requests are being evaluated on a joint basis by the Divisions of Highways and Emergency Medical Services and Highway Safety. The Regional Trauma Coordinator is working closely with local agencies to better establish the needs and resources of that community.

The general decreasing interest of mortuary services to provide ambulance transfer for injured patients is a state and nationwide problem. The Division of Emergency Medical Services, in conjunction with the Division of Highways, is working to supplement these deficiencies by obtaining matching federal funding from the Department of Transportation (D.O.T.). These funding requests for adequately equipped and standardized vehicles are being aligned to Trauma Centers and other care centers with two-way radio capability. The Ambulance Act, House Bill 2429, not read in the fall session of the Legislature, but to be brought to the floor this year, is a necessary first step in developing standard care consistent with safe and optimal transfer of patients from the scene of the accident to care centers. The Enabling Act (H.B. 2412) will allow local communities to levy taxes to subsidize ambulance programs on their own initiative.

The problem of ambulance services is not a simple one and must be dealt with on an individual community basis. However, with the existing capabilities of ambulance personnel and equipment and those which can be made available through federal matching funds, there is no excuse at the present time for not demanding the minimal nationally accepted standards for emergency care for each citizen in the State of Illinois.

As the Illinois Plan for Development of

Trauma Care Centers is based on the fact that not every emergency room in the state can or should provide comprehensive care for the critically ill and injured, it is also axiomatic that not every community will be able to adequately sustain an ambulance service. Other mechanisms for providing such care are possible and these are being explored.

Communications

The basic Illinois Hospital Association (I.H.A.) radio communication system has been expanded. All Trauma Centers now operate the two-way Hospital Emergency Administration Radio System (HEAR). This initial effort to develop an Emergency Radio Communications System has been augmented with an important change in program direction. This change has been to develop, using similar equipment, a hospital (base station) and ambulance (mobile unit) communications system. To better link some hospitals, a system of private "hot-line" telephones from Local to Regional or Areawide Centers is being evaluated. In special circumstances, high frequency (microwave) transmission from Local Centers in rural areas to advanced centers is being developed. The State of Illinois Emergency Radio Frequency has been established at 155:340 MHR_z with a four channel capability to include for two-way radio communications, dispatching and electrophysiologic data transmitting.

Results

The total number of admissions to hospitals for major accident care, as tallied on the Trauma Registry^{10,11} exceeds 5,000 patients. These patients have varied in their type of injury, and include highway, home and industrial accidents. It is apparent that there has been increasing patient load of critically injured patients to the designated trauma centers. During the first three months of operation there were 2051 admissions to six regional Trauma Centers with an overall mortality rate of 2.2%. There has not been, however, an appreciable increase in the patient load of other (noncritical) emergency visits to these centers. Extensive educational programs to define the Trauma Center's special care potential role in the community has been the job of the Division of Emergency Medical Services and Highway Safety. Where deficiencies exist within the Statewide Trauma System, these have been compensated for by early and safe transfer of patients to other centers and by further development of these centers.

Status report : trauma center

Also, the increased interest in those professionals working at these centers has been apparent and has been responsible for the continual improved care for the critically injured across the state.

Problems and Future Progress

Future progress during the next year will be along the lines of further implementation and completion of the forty centers. These will be developed along the lines of areawide project planning and located in strategic areas where medical resources capability is available. The allocation of these centers will be a conjoint effort between the community and state through the mechanisms of the community health planning councils. The input into the council decisions is from professional societies, individuals, and lay groups within the community. Once the community has chosen the facility they feel will best serve the needs of the accident victims within their purview, the Division of Emergency Medical Services and Highway Safety will confer with the general overall areawide plan and develop the facilities where indicated.

The implementation of Senate Bill 568, which allows for the consolidation of emergency medical services and the self categorization of facility capability in the three basic levels of emergency care, will be fostered. Community hospitals without the care capability of being local trauma centers will be assisted in their attempts to be designated as a non-trauma receiving facility and be relieved of the responsibility for the care of the critically injured.

Areawide Planning

This areawide planning approach is being implemented in the Northeast Chicago Area where a 17-hospital district has designated its care capabilities in a written plan to the State of Illinois Division of Emergency Medical Services, Department of Public Health.

Also, consistent with the state law, the Trauma Coordinators are developing liaison with the Civil Defense and the Environmental Protection Agency. In case of a catastrophe, medical resources will be made immediately available through contact with the Trauma Center and coordination by the Trauma Coordinator.

The identification of other health care resources for accident victims such as the Burn Unit at the Cook County Hospital, Memorial Hospital in Springfield, and the newly develop-

ing Burn Center in Peoria has supported the total care capability in the state. The special Regional Trauma Centers at the Children's Memorial Hospital and Northwestern's Passavant Hospital have been utilized and are excellent examples of the sophisticated care capability in the state which is now available to all citizens and is only a matter of a plane trip or ambulance trip away. ◀

References

1. Special Message on Health Care, Governor Richard B. Ogilvie, April 1, 1971. State of Illinois Printing Office, Springfield, Illinois.
2. Flashner, B. A. and Boyd, D. R.: "The critically injured patient: a plan for the organization of a statewide system of trauma facilities," *I.M.J.*, 139:256-265, March, 1971.
3. Boyd, D. R. and Flashner, B. A.: *THE CRITICALLY INJURED PATIENT—CONCEPT AND THE ILLINOIS STATEWIDE PLAN FOR TRAUMA CENTERS*. Dept. of Public Health Printers, Springfield, Ill., 1971.
4. State of Illinois Executive Order #7—Regionalization, June, 1971. Governor's Office, Springfield, Illinois.
5. Basic Training Program for Emergency Medical Technician-Ambulance: Concepts and Recommendations. U.S. Government Printing Office, Washington, D.C., 1969.
6. Basic Training Program for Emergency Medical Technician-Ambulance: Course Guide and Course Coordinator Program. U.S. Government Printing Office, Washington, D.C., 1969.
7. Basic Training Program for Emergency Medical Technician-Ambulance: Instructor's Lesson Plans. U.S. Government Printing Office, Washington, D.C., 1970.
8. Registry Emergency Medical Technician-Ambulance, P.O. Box 17251, Charlotte, N.C. 28211.
9. *Trauma Center Newsletter*, David R. Boyd, M.D.C.M., Editor. Trauma Core Library, Department of Surgery, Abraham Lincoln School of Medicine, P.O. Box 6998, Chicago, Illinois 60680.
10. Boyd, D. R., Rappaport, D. M., Marbarger, J. P., Baker, R. J., and Nyhus, L. M.: Computerized trauma registry: a new method for categorizing physical injuries. *Aero. Med.*, 42:607-615. 1971.
11. Boyd, D. R.: "A trauma registry: editorial," *J. of Trauma*, 11:364, 1971.

Policy Manual of the Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the standard taken by the House of Delegates to the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House may appear as a portion of the annual report of the Policy Committee, or they may be contained in other reports to the House. The final statements for publication in this Policy Manual are to be prepared by the Policy Committee. Any member of the Illinois State Medical Society may submit a policy statement for consideration.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois, and the Society must recognize such policy and until it has been changed at the national level.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic processes.

Abortion

The Illinois State Medical Society is opposed to induced abortion except when under the following conditions:

1. There exists documentation of a severe threat to the health or life of the mother, or
2. There is documented medical evidence that the conceptus may be born with incapacitating physical or mental abnormality, or
3. There is documented evidence that continuation of a pregnancy resulting from statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient, and
4. Two other physicians chosen because of their recognized professional competence have examined the patient and concurred in writing, and
5. The procedure is performed in a hospital legally licensed and approved by the State of Illinois for the care of maternity patients.

Alcoholism

"Since alcoholism has been widely regarded as a disease for some time and because it is impossible to differentiate immediately between a chronic alcoholic and any other intoxicated person, the individual who is acutely ill from alcohol ingestion should be considered a health problem and therefore be adjudicated within the purview of the medical and other health professions."

AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Audits & Surveys

(Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

Autonomy of County Medical Societies

No ruling of any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association, or with the Constitution and Bylaws of the Illinois State Medical Society.

In all other areas, the county society shall be autonomous.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

Blood Procurement

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the

community and to encourage and assist in developing Community Health Week activities during the winter or spring of the year.

Comprehensive Health Planning

Upgrading of local health facilities should be implemented through Comprehensive Health Planning on a home rule basis rather than through metropolitan-oriented advisory services.

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should join with other interested parties in developing a multi-organizational approach to continuing medical education and all members should be encouraged to participate in the AMA Physician Recognition Award.

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

Cultists, Association with (Association with Osteopaths—see "O")

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Discrimination—(see “Freedom of Choice”)

Drugs, Prescriptions

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration at the spring meeting of the Board.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

Education, Primary and Secondary

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees.

Individuals covered by various fee schedules shall receive the best type medical care in all cases, and the physicians involved shall be remunerated according to the accepted fee schedule. Fees should be commensurate with services rendered.

Financial Policies (also see “Assessments,” etc.)

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees; however, such recommendations must be approved by the Board.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

(7) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost. Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, etc., and any other area which involves the health of the residents of this State.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

Hospital Assessments—See Assessments

Hospital Committees (Dealing with physician-patient relationship)

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

Hospital-Medical Staff-Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education.

Hospital Records and Their Availability

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when needed, to insurance companies, governmental agencies, consulting physicians, etc.

Hospital Staff Privileges

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

Immunization Program

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

Impartial Medical Testimony

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Insurance Plans

Physicians are urged to cooperate with voluntary health insurance plans approved by the Illinois State Medical Society.

Fixed fee schedules should not be accepted. All fees should be based upon the usual and customary fee concept.

Insurance programs for the membership of the Illinois State Medical Society should be studied and implemented by the proper committee. Major medical and comprehensive hospital group coverage should be part of this insurance package.

Journal Publication

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Lay Employees and Their Prerogatives

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

- change existing policy
- establish new policy
- request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

Medical Representation in Government Planning

In health programs financed by government funding in

an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

Membership in the Illinois Association of the Professions is encouraged. Medicine should be well represented among these allied professional groups and the growth and development of the Association is of concern to ISMS economically, politically and scientifically.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

Mental Health

Mental health planning should be implemented at the community level. County medical societies should be kept aware of their responsibilities to assist in developing improved mental health facilities.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Nurses—Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

Nutrition

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the Nutrition Committee and the Council on Environmental and Community Health in 1971.

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of all physicians involved in industrial work,

Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Policy Statements

Policy statements shall be defined as guide lines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

Polls, Opinion

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion HAS BEEN expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Press

All county medical societies should cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Publication of Research Data

In releasing research material for publication in the

Illinois Medical Journal, or any other media, extreme care should be exercised. The welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state society advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and co-operating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Public Health Departments

"Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

"Full-time modern local Health Departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support."

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Rebates

1) "In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical." This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon the recommendation of the committee with the approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

Specialty Society Representation on ISMS Councils

For the improvement of communication and the dis-

cussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

Woman's Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

Index to Policy Manual

Abortion	63	Discrimination (See "Freedom of Choice")	65
Alcoholism	63	Drugs, Prescriptions	65
AMA-ERF	63	Dues, Recommendation of the Board to the House	65
Assessments	63	Education, Primary and Secondary	65
Athletic Programs	63	Ethics	65
Audits & Surveys	63	Examinations	65
Autonomy of County Medical Societies	64	Facility Medical Board (Physicians)	65
Birth Certificates	64	Federal Funds	65
Birth Control	64	Fee Schedules	65
Blood Procurement	64	Financial Policies	65
Budgets (see Financial Policies)	64	(also see "Assessments," etc.)	
Committee Appointments	64	Freedom of Choice	65
Communicable Diseases	64	Foundations for Medical Care	65
Community Health Week	64	Health Care—Ancillary Services	65
Comprehensive Health Planning	64	Health Care Costs	66
Conflict of Interest	64	Health Careers	66
Constitution and Bylaws	64	Hospitals	66
Continuing Education	64	Hospital Assessments—See Assessments	66
Co-Operation with the American		Hospital Committees (Dealing with Physician-	
Medical Association	64	Patient Relationship)	66
Cultists, Association with	64	Hospital-Medical Staff-Management Relationship	66
(Association with Osteopaths—see "O")		Hospital Records and Their Availability	66
Disaster Control	64	Hospital Staff Privileges	66

House of Delegates, Special Meetings of.....	66	Osteopaths, Association with	68
Immunization Program	66	Placement Service	68
Impartial Medical Testimony	66	Policy Statements	68
Indigent, The Care of the	66	Polls, Opinion	68
Individual Rights	66	Prepayment Plans and Organizations	68
Insurance Plans	66	Press	68
Journal Publication	66	Publication of Research Data	68
Laboratories	66	Public Affairs	68
Lay Employees and Their Prerogatives.....	66	Public Aid	68
Legal Counsel	67	Public Health Departments	68
Legislation	67	Public Safety	68
Mailing List	67	Rebates	68
Medical Care, Provision of	67	Reference Committee Appointments	69
Medical Examiners	67	Reference Service	69
Medical Representation in Government Planning.....	67	Rehabilitation	69
Membership in Paramedical and		Relative Value	69
Service Organizations	67	Special Society Representation on	
Membership of Osteopathic Physicians in ISMS	67	ISMS Councils	69
Mental Health	67	Stationery, Use of Official	69
Nurses—Shortage	67	Surveys	69
Nutrition	67	Veterans Administration	69
Occupational Health	67	Woman's Auxiliary	69

Family Practice Board sets certifying exam

The American Board of Family Practice will give its next examination for certification over a two-day period, April 29-30, in various centers throughout the United States.

Information regarding the examination may be obtained by writing Dr. Nicholas J. Pisacano,

secretary, American Board of Family Practice, University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

The deadline for receiving completed applications in the board office is *February 1*.

Thievery in medical school libraries

Early in 1970 the librarian of a medical school in Philadelphia announced to his faculty that the costs that year for replacing books and journals "missing" from its library would be an estimated \$7,500 to \$10,000, or 10% of the annual acquisitions budget. I could hardly believe his news. It implied that the students, or faculty, or other users of this library include some men and women with the morality of the shop-lifter. But there was a grimmer possibility—that this blight might not be peculiar to this school but might be a plague in other American schools.

Twenty-one libraries reported no large problems with theft. But fifteen, or 40%, did report that they have had major losses. The highest rate of loss was equal to a cost of about 10% of the annual acquisition budget—in two schools, including the Philadelphia school. Two more schools reported losses at a cost rate of about five per cent. But losses in some schools were much higher in specific parts of their collections. One medical school in Boston reported that an inventory in January 1970 "indicated that 25% of the books had been lost or stolen; the last shelf list reading in 1962 indicated a loss of five per cent." In the same library the loss of bound journals is "up only slightly over the three per cent loss of 1962," but its loss of unbound journals is so great that it must spend over \$2,000 per year to replace lost issues before binding. Most of the librarians believe that thefts now are running at much higher rates than 10 to 20 years ago. (Thievery in Medical-School Libraries. (Editorials) *Annals of Internal Medicine* 75:3 (Sept) 1971, pgs. 469-70.)

Management of congenital defects of the anterior abdominal wall

AMBROSE PARE WROTE the first clear description of omphalocele in 1634¹ He noted the serious nature of this lesion and the dismal outlook for survival. The first survivor is recorded in 1806.² Scarpa pointed out the difficulties associated with the repair of large omphaloceles in 1814.³ To meet this problem, Ahfeld in 1899 proposed non-operative management.⁴ An alternative to complete primary closure i.e. closure with skin while leaving the fascia open was suggested by Olshousen in 1887.⁵ Repair of a ruptured omphalocele with survival was probably first carried out in 1913.⁶ Gastroschisis had been described in 1733,⁷ but the first surgical success in treating this lesion was not reported until 1943.⁸

Embryology

Four tissue folds which meet at the umbilicus are responsible for formation of the abdominal wall. Failure of the viscera to return from its normal herniation into the umbilical cord and of the embryonic folds to close at that site results in an omphalocele.

The defect in gastroschisis is lateral to the umbilical ring and no sac is present. Hence, the mechanism of its production differs from that producing omphalocele; as yet there is no agreement upon a precise explanation of this facet of abnormal embryology.

Clinical Presentation

An omphalocele may show all gradations in size from a slightly enlarged cord to an umbilical defect which spans the entire width of the abdomen. The contents may vary from a single knuckle of bowel up to a major portion of the solid and hollow viscera of the abdomen. The sac is composed of an inner layer of peritoneum and an outer layer of amnion. It is occasionally ruptured prior to or during delivery.

A high percentage of associated anomalies supports the concept that omphalocele may result from a general interference with development early in embryonic life. Rickham reports 205 associated anomalies in 83 cases.⁹ From 11 reports in the literature the average incidence is 38%.¹⁰ Anomalies of the GI tract are the most common. Non-rotation of the intestine, Meckle's diverticulum or patent omphalomesenteric duct, and small bowel atresia or stenosis represent the bulk of these anomalies. Of extra intestinal anomalies those of the GU tract are most common with intra-thoracic defects being next in incidence.

Omphalocele may on occasion be a part of other syndromes or major defects. A syndrome of somatic gigantism, macroglossia, omphalocele and other defects was described in 1964^{11,12} and recently has been extensively documented.¹³ Although further definitive information relating to its significance may be forthcoming, at the present two implications are clear: (1) the macroglossia may increase the hazards of anesthetic manipulations if surgical repair is undertaken

Congenital defects

Table I

	Omphalocele	Gastroschisis
Location	In umbilical ring	Paraumbilical (usually right side)
Sac	Present	Absent
Cord	Inserts at apex of sac	Normal insertion at edge of defect
Contents of sac	Any portion of intestinal tract, frequently liver	Any of intestinal tract including stomach, liver rarely if ever
Abnormal intestinal rotation	Common	Common
Shortening of gut	Absent	Common
Atresias and/or stenoses	Occasionally present	Common
Chemical peritonitis	Only if sac ruptured before delivery	Always present
Extra-abdominal anomalies	Common	Rare

and; (2) in this syndrome neonatal hypoglycemia is common and must be recognized and treated. Omphalocele also occurs as part of the vesico-intestinal fissure defect and as part of a syndrome including midline defects of the diaphragm and pericardium associated with a sternal cleft.^{14,15}

Gastroschisis

The defect in gastroschisis is vertical, para-umbilical, and in all but a few reported cases on the right side. There is no sac and the umbilical cord has a normal insertion at the edge of the defect. A major portion of the intestinal tract often including the stomach may be herniated, but in contrast to omphalocele, the liver rarely if ever presents through the defect. The protruded viscera having been exposed to amniotic fluid always exhibits chemical peritonitis the degree of which may be mild or so extensive that the viscera are obscured by a thick edematous peel. The explanation for this variation is one of the unanswered questions regarding this lesion. The

small intestine is commonly shorter than normal, sometimes strikingly so. Intestinal atresias and/or stenosis are frequently found, but extra abdominal anomalies are rare with gastroschisis. Table 1 tabulates the features which differentiate omphalocele and gastroschisis.

Problems of Treatment

Omphalocele

Surgical closure has not achieved satisfactory results in the past. Review of the literature reveals an average survival of 50% in six series.¹⁶⁻²¹ The major deterrent to improved survival rates has been the problem of returning to an underdeveloped abdomen a volume of viscera which had never established "resident rights" therein. In the moderate size or large omphalocele primary complete closure may result in an excessive increase in intra-abdominal pressure producing elevation of the diaphragm with compromise of respiratory function. In addition venous return is restricted with resulting edema of the lower extremities and impaired diastolic filling of the heart. The intestinal tract is also affected with resultant ileus, vascular embarrassment, and occasionally perforation.

To avoid an excessive increase in intra-abdominal pressure coverage by mobilized skin with no attempt to close the fascia has been used.^{5,22} This approach accepts that complete closure will require a second stage. This technique has on occasion been successful but has frequently been inadequate due to several factors. Often the available skin is inadequate for a closure without undue tension and the baby succumbs after the first stage.²³ In the case in which the first stage is successful two technical problems occur, adherence of the viscera to the skin makes the second stage dissection difficult, but more importantly, the skin covering stretches and the rectus muscles pull together behind the ventral hernia with the result that the skin covered sac enlarges with growth instead of the underdeveloped abdomen.²⁴ This occurrence renders the second stage virtually as difficult and hazardous as an initial complete closure would have been.

An alternate technique is that described by Schuster.²⁴ This technique uses silon sheeting to create an artificial accessory compartment for the excess viscera which the abdomen cannot accept immediately. In stages which are repeated at intervals of two to three days a portion of the silon is removed reducing the extra-abdomi-

nal viscera into the peritoneal cavity gradually. When adequate reduction is obtained the remaining silon is removed and closure completed by a fascial and skin closure.

Modifying the 1899 technique of Ahlfeld, in which a non-operative technique was used, Grob in 1957 publicized an approach utilizing mercurochrome applications to the sac to encourage its toughening and cicatrization until contraction and epithelization produced closure.²⁵ By this procedure the viscera is slowly returned into the abdomen and the residual fascial defect can be closed at a later time, although on occasion no closure is necessary. This approach has been neglected in favor of various modifications of surgical repair but four series from the literature in which a non-operative approach was used report survival rates of 100%,²⁰ 80%,²⁶ 87%²⁷ and 93%.²³ Interestingly these series generally consist of the largest cases encountered. Although with non-operative management the search for concomitant intra-abdominal abnormalities is not possible, this has rarely resulted in problems. The occasional occurrence of intestinal obstruction during the course of non-operative management has resulted from adherence of small bowel in the sac rather than from the malrotation. It has been noted that in such an instance when obstruction occurs after several weeks the abdominal cavity has enlarged, the sac has contracted, and closure will usually be well tolerated.²³

Gastroschisis

Treatment is immediate and operative. Two problems affect the outcome: the chemical peritonitis may be so extensive that the bowel resumes function slowly or not at all; and the problem of returning viscera to the underdeveloped abdomen is present. Removal of the inflammatory peel from the bowel has been advocated but is extremely difficult and generally too productive of trauma and hemorrhage.

Current Choice of Management

In the omphalocele with a small facial defect surgical repair is safe but offers no particular advantage over non-operative treatment. In favor of surgery is the shorter hospitalization and prevention of obstruction in the "pear shaped" omphalocele with a small facial ring and a disproportionately large sac. In favor of non-operative therapy is the avoidance of an anesthetic if the baby is premature or has other problems and the additional advantage that

often in the small omphalocele complete closure occurs and surgery is not required at any stage.

With rupture of the sac prior to or during delivery immediate surgery is mandatory. Primary complete closure should only be done if there is no suggestion of excessive increase in intra-abdominal pressure subsequent to reduction of the aberrant viscera. Closure with silon sheet as previously noted offers a safe approach and should be used if any question exists as to the safety of complete one stage closure.

In the large omphalocele with an intact sac non-operative management is preferred. The sac is painted daily for three days with 0.5% AgNO₃.^{*} Following this the silver nitrate is applied only if a moist spot appears. This procedure must be carried out in the hospital since the risk of later rupture of the sac, although rare, exists. The development of intestinal obstruction in the sac will occasionally necessitate a change to operative treatment. Rather than wait for complete closure, which required an average of 60 days,²³ the infant is observed closely and when sufficient contraction of the sac and concomitant enlargement of the abdomen has occurred, safe one-stage repair is carried out. The timing of surgical intervention must be based on observation and experience but in the moderate size to large omphalocele will require from three to five weeks before surgery is considered. With this approach antibiotics are used for the first week only.

Closure with prosthetic material in stages for the present remains second choice. The necessity for at least two anesthetics militates against

* * *

**A question has been raised as to the possible toxicity of mercurochrome used in this technique. This has prompted a change to AgNO₃.*

HUGH V. FIROR, M.D., is chairman of the Department of Pediatric Surgery at Cook County Hospital, and chief of Pediatric Surgery at the University of Illinois Research and Educational Hospitals in Chicago. Dr. Firor is associate professor of surgery at the Abraham Lincoln School of Medicine at the University of Illinois and a Fellow of the American College of Surgeons and of the American Academy of Pediatrics. He received his M.D. degree from the University of Maryland School of Medicine and did postgraduate training in pediatric surgery in Cape Town, South Africa for two years.



Congenital defects

its use if the baby has problems of prematurity, macroglossia, or cardio-respiratory abnormalities. Also, the problem of infection is genuine although not usually of a severity to necessitate removal of the prosthesis.

With gastroschisis, after correcting any associated intestinal problems, closure with silon sheeting is probably the preferred approach with closure being completed in stages. Primary complete closure may occasionally be safe. A prolonged period before resumption of intestinal function can be regularly anticipated. During this recovery period decompression by a gastrotomy and the use of intravenous hyperalimentation, as recently described,²⁸ may contribute to a successful outcome.

Summary

1. Omphalocele and gastroschisis differ embryologically but present many similar problems in management.

2. Surgical repair in the past has achieved a survival rate of 50%.
3. The problem of excess intra-abdominal pressure following surgical closure has been the major cause of death in these infants.
4. With the gastroschisis or ruptured omphalocele a recently described technique of closure in stages with plastic material offers a greatly improved chance of survival.
5. In a small omphalocele surgical closure is safe but offers no advantage over non-operative treatment. With the latter approach many of these will close completely and not require surgery at any stage.
6. In the intact omphalocele excellent results are obtainable by non-operative management. A good alternative is closure with prosthetic material.

References

The bibliography for this article can be obtained by writing: *Illinois Medical Journal*, 360 N. Michigan Avenue, Chicago, Illinois 60601.

Physician Self-Assessment Program offered

The Physician Self-Assessment Program, demonstrated at the ISMS Annual Meeting in May at the Arlington Park Towers Hotel, has been extended into an on-going program that will become operational in January, 1972.

Developed and conducted by the Center for Educational Development, University of Illinois College of Medicine, the program differs from other self-tests in that it will probe more than knowledge; each month participants will receive a packet of material which will include one or more of the following items:

1. *Problem in patient management*: Using the clinical simulation technique, a patient's problem is presented for the physician to evaluate and manage.
2. *Simple data interpretation*: The physician receives materials which provide him with the opportunity to interpret X-rays, EKG's, blood smears, heart or pulmonary sounds, etc.
3. *Complete data interpretation*: The physician is presented with a patient's history, physical, laboratory findings and course of illness so that he may determine his own diagnostic acumen.
4. *Information recall*: Multiple-choice testing of general fund of information in various areas.

5. *Telephone emergency care*: Pre-arranged phone call from a person simulating an emergency situation, e.g. suicide, poisoning, accident, chest pain, abdominal pain, bleeding, etc.

The program will require approximately five to six hours of a physician's time each month. The problems will be so designed that each successive experience will build upon the preceding one, thereby providing the opportunity to reinforce previous learning.

Answer sheets are returned to the University of Illinois College of Medicine for diagnostic evaluation. In the subsequent monthly installment, the participant receives his diagnostic evaluation, a summary of performance, a discussion of common errors, and general discussion of the identified educational need by an appropriate consultant, and suggested articles for further study.

The fee is \$100 per annum for Illinois physicians and \$125 per annum for out-of-state physicians. For an application or information write to:

M. Lory Campbell, M.D., Chief
Continuing Education Section
Center for Educational Development
University of Illinois College of Medicine
835 S. Wolcott Avenue
Chicago, Illinois 60612

BY KENNETH M. CAMPIONE, M.D./CHICAGO

Heart to head circulation time

AN OBJECTIVE SIMPLE method of "heart to head circulation time" by detection of transit of radioactive tagged bolus of blood is proposed. This test involves materials and equipment generally available in most hospitals and can be carried out in a few seconds with no special technical skill. The method requires only a simple venous injection of a small amount of radioactive labeled human serum albumin and is performed easily at the bedside. The subjective appreciation time which has detracted from other circulation methods is obviated. Correlation with clinically observed features of congestive failure is quite good.

Introduction

Measurement of blood velocity has generally been considered a useful index of cardiac pump adequacy. This measurement is expressed as the time for a bolus of blood to travel from one point to another in the circulatory system. The bolus must be labeled with some sort of "tag." The first point is usually indicated by the time of injection into a peripheral vein. The second point is designated by the detection of the arrival time at a distal point such as the tongue (as reported by the patient with Decolin tag) or the lung (as reported by examiner with an Ether tag). Unfortunately, the precise timing of these points has been questioned because of a dependence on subjective observations.¹ An objective measurement of blood velocity is now suggested.

Method

A small quantity of I_{131} labeled human serum albumin (usually 15-20 microcuries) is injected

rapidly into a peripheral vein with a tuberculin syringe.

Scintillation counters positioned over the precordium (third interspace in the mid sternal line) and over the mid forehead detect the arrival of the radioactive blood bolus first in the heart chambers and subsequently in the head. The detected signals from the scintillation counters are transmitted through individual rate meters* to respective simultaneously recording rectilinear galvanometric recorders. The first point of upward deflection of the recording pen from the baseline is taken as the arrival time of the radioactive bolus of blood at the first (heart) point. The beginning of the upward deflection at the second (head) site is taken as the second arrival time. The time between these two points is called the "heart to head circulation time."

*Picker models 2801 D and 5846.

Results

Two groups of individuals are compared. The

Circulation time

Chart 1
Normals

	Male					Female				
	Age	Blood Volume		C.I.	C.T.	Age	Blood Volume		C.I.	C.T.
		Total, L	ml/kg				Total, L	ml/kg		
Normals	22	5.98	69.9	4.76	9.6	22	4.10	72.2	3.31	11.6
	22	5.94	75.6	5.73	9.9	23	3.78	68.1	3.17	10.3
	25	5.83	73.5	5.74	10.9	21	3.92	60.0	2.72	8.8
	27	5.63	71.5	3.69	12.3	22	4.07	70.1	3.15	10.1
	24	7.03	61.2	4.21	10.3	25	3.30	69.2	3.04	11.8
	19	4.52	68.3	4.70	8.5	18	3.23	61.5	5.21	9.3
	42	5.86	74.4	5.03	9.1	63	2.97	53.5	2.91	11.4
	45	5.61	61.2	3.72	12.3	26	4.05	77.4	4.31	9.0
	20	4.96	59.3	5.34	8.6	51	3.54	65.2	3.31	10.2
	61	5.37	60.0	4.29	12.0	24	4.56	72.0	4.40	8.0
	30	4.08	59.0	4.13	10.2	23	4.46	68.6	5.38	8.6
	32	4.87	57.8	5.29	7.7	31	4.47	76.4	4.44	8.4
	42	3.44	63.7	4.53	9.4	26	4.70	79.3	3.20	9.3
	27	5.96	75.4	4.83	9.3	27	3.61	64.0	4.28	8.3
	38	4.65	71.3	4.78	10.9	22	2.92	55.5	4.74	9.2
	24	4.86	67.4	5.02	8.8	43	3.65	83.8	4.86	8.8
	37	5.68	70.0	3.82	10.9	22	3.92	73.9	4.18	10.5
Total No. Average S. Deviation Range	17	17	17	17	17	17	17	17	17	17
	32	5.31	67.0	4.68	10.0	29	3.84	68.8	3.92	9.6
		0.86	6.3	0.63	1.4		0.54	8.2	0.86	1.2
		4.45-	60.7-	4.05-	8.6-		3.30-	60.6-	3.06-	8.4-
		6.17	73.3	5.31	11.4		4.38	77.0	4.78	10.8

C.I.=Cardiac Index (L/Min./Sq. Meter) C.T.=Heart to Head Circulation Time (Seconds)

Chart 2
Congestive Heart Failure

	Patient	Age	Blood Volume		C.I.	C.T.
			Total, L	ml/kg		
Congestive Failures	J.C.	55	3.86	58.3	2.51	14.6
	H.C.	70	3.08	59.2	2.51	16.8
	R.C.	86	3.73	76.2	2.03	18.5
	C.C.	56	4.73	68.2	3.00	12.4
	E.D.	61	6.43	81.6	2.12	25.1
	S.G.	69	4.22	69.8	1.16	34.7
	F.H.	85	3.62	66.3	1.79	19.2
	M.H.	78	4.36	68.9	1.43	19.0
	W.J.	70	4.85	68.0	1.82	17.9
	H.K.	61	7.52	72.2	2.35	17.6
	J.K.	53	8.66	97.0	1.97	30.6
	V.K.	49	4.52	95.0	1.57	23.1
	R.L.	80	3.45	64.7	2.26	22.0
	M.N.	81	3.02	55.0	1.95	15.9
	G.P.	62	6.42	89.0	1.57	26.2
	P.P.	49	3.97	77.4	1.31	21.4
	V.R.	56	5.27	77.5	2.83	15.4
	G.R.	62	3.06	65.1	2.18	15.4
	M.R.	80	3.75	77.2	3.14	15.8
	G.S.	62	3.93	67.0	1.90	19.3
	L.W.	67	6.17	69.4	1.49	17.3
Total No. Average S. Deviation Range		21	21	21	21	21
		66	4.70	72.5	1.98	19.9
			1.53	11.1	0.56	5.5
			3.17-	61.4-	1.42-	14.4-
			6.23	83.6	2.54	25.4
Normals		34	34	34	34	34
		30	4.57	67.9	4.30	9.8
			1.03	7.2	0.84	1.3
			3.54-	60.7-	3.46-	8.5-
			5.60	75.1	5.14	11.1

C.I.=Cardiac Index (L/Min./Sq. Meter)
C.T.=Heart to Head Circulation Time (Seconds)

first group consists of 17 female and 17 male normal subjects, mostly medical students, technicians, and hospital personnel without evidence of circulatory disease. The average age of the entire group was 30 years.

The second group comprised 21 patients with overt congestive heart failure, as evidenced by symptoms of dyspnea and orthopnea, and signs of hepatomegaly and or peripheral edema. "Heart to head circulation times" of the two groups are shown in charts 1 and 2. Differentiation between normal subjects and patients with clinical congestive heart failure by such circulation times was statistically highly significant ($P < 0.001$).

Cardiac indices derived by analysis of the precordial primary passage curve (radiocardiograms)² reflect the depressed cardiac performance in the congestive heart failure patients when compared to the normal subjects ($P < 0.001$). Possibly due to technical reasons discussed by other investigators,³ or because of their younger age, range total blood volume measurements in the normal group were not found to be substantially different than that of the congestive heart failure patients ($P > .70$). Blood volume when expressed as ml/kg in the heart failure individuals was also not significantly increased over that of the normal group ($P > .05$). The "heart to head circulation time" measures the difference in the time of appearance intravenously and peripherally administered isotope at these two regions. It is realized that the actual detection depends on the concentration of the isotope reaching a measurable level at each of these two points.

Discussion

The easy identification of appearance times provides the isotope method with an objectiveness not found with the other commonly used indicators and is considered a most important advantage.

The heart to head circulation depends first on detection of the isotope as it enters the great central veins of the right heart. The second point of detection is when the isotope enters the cerebral circulation. The time elapsing between these two points probably represents the time for transit of the isotope bolus through the right heart pulmonary circulation, left heart and arterial peripheral vessels to the head. This measurement would seem to be influenced by both the velocity of blood flow and the size of the central blood pool.

Both of these factors are conceded to be increased in congestive heart failure. Our patients with heart failure did not have significant increases in total blood volume but we have not as yet extended our studies to a calculation of central blood volume. The times we have reported in the congestive heart failure group seem to fairly closely reflect the essential defects in underlying hemodynamic factors in this syndrome. We might expect that future studies will demonstrate that earlier degrees of circulatory failure would result in lesser prolongations of the heart to head circulation time. ◀

Acknowledgement

The valuable technical assistance of Akira Nakamura is greatly acknowledged. Supported by a grant (RR-48) from the General Clinical Research Centers Program of the Division of Research Resources, National Institutes of Health.

References

1. Hitzig, W. M.: "Circulation time. Indicator dilution methods." *CARDIOLOGY-METHODS*, Ed Luisada, AA. McGraw-Hill, New York, Vol. 2:4-145, 1959.
2. Zipf, R. E., McGuire, T. F., Webber, J. M., and Grove, G. R.: "Determination of cardiac output by means of external monitoring of radioisotope injected intravenously," *Am. J. of Clin. Path.*, 28:134, 1957.
3. Samet, P., Fritts, H. W., Fishman, A. P., and Courmand, A.: "The blood volume in heart disease." *J. Clin. Invest.*, 36:211, 1957.

KENNETH M. CAMPIONE, M.D., maintains a private practice in cardiology at Passavant Memorial Hospital, and is an assistant professor at Northwestern University. He received his M.D. degree from the University of Chicago. Dr. Campione is currently on the Board of Governors of the Chicago Heart Association, and chairman of the Membership Committee of the Association. In addition, he is the director of the Chicago Medical Department of Union Carbide Corporation.





new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

New Single Chemicals

CLEOCIN PALMITATE Antibiotic R

Manufacturer: Upjohn

Nonproprietary name: Clindamycin palmitate

Indications: Treatment of upper and lower respiratory tract infections, including Group A streptococcal pharyngitis/tonsilitis.

Contraindications: Known hypersensitivity to preparations containing clindamycin or lincomycin.

Warning: Not to be given with erythromycin.

Dosage: See package insert

Supplied: Powder, reconstituted each 5 cc. contains equivalent to 75 mg. clindamycin base.

NARCAN Antagonist R

Manufacturer: Lilly

Nonproprietary name: Naloxone hydrochloride

Indications: Complete or partial reversal of narcotic and pentazocine depression. Diagnosing suspected opiate overdosage.

Contraindications: Known hypersensitivity to drug.

Dosage: Initial 0.4 mg. i.v., i.m., s.c.

Supplied: Vials, each cc. contains 0.4 mg.

Duplicate Single Products

BRISTAMYCIN Antibiotic R

Manufacturer: Bristol

Nonproprietary name: Erythromycin stearate

Indications: Infections due to organisms listed in package insert.

Contraindications: Hypersensitivity to drug

Dosage: Adults, 0.25 to 1 gm. every 6 hrs.

Children, 15 to 25 mg./lb./day in divided doses depending on severity of infection.

Supplied: Tablets, 250 mg.

K-LOR Oral potassium chloride supplement R

Manufacturer: Abbott

Nonproprietary name: Potassium chloride

Indications: Treatment and prevention of hypokalemia and hypochloremic alkalosis.

Contraindications: Impaired renal function, Addison's disease or hyperkalemia from any cause.

Dosage: As prescribed

Supplied: Powder, each 5 gm. packet contains 20 mEq. of potassium, 20 mEq. chloride.

Duplicate Single Product

TRAVASE (Sutilains) Enzyme R

Manufacturer: Travenol

Composition: Proteolytic enzymes elaborated by *B subtilis*.

Indications: For wound debridement

Contraindications: For wounds containing exposed nerves or communicating with major body cavities; fungating neoplastic ulcers, in women of child bearing potential.

Dosage: Apply once daily, or 2 or 3 times if needed.

Supplied: Ointment, 1 gm. contains approximately 82,000 casein units.

Combination Products

IBERLATE Pediatric hematinic vitamin R

Manufacturer: Abbott

Composition: Each 4 gm. contains:

Ferrous sulfate	75 mg.
Ascorbic acid	60 mg.
Niacinamide	4.5 mg.
Thiamine mononitrate	1.0 mg.
Riboflavin	1.5 mg.
Pyridoxine HCl	1.0 mg.
Folic acid	100 mcg.
Vitamin B ₁₂	3.0 mcg.

Indications: Nutritional deficiencies responding to iron and folic acid.

Contraindications: Patients with juvenile pernicious anemia

Dosage: Differs if supplemental or therapeutic use
—see package insert.

Supplied: Powder; reconstituted with minimum of
3 oz. liquid.

20% SODIUM CHLORIDE Hospital solution R

Manufacturer: Abbott

Composition: Each 100 ml. contains:

Sodium chloride USP 20 gm.

Disodium edetate (anhydrous) 10 gm.

Indications: For transabdominal intra-amniotic instillation.

Contraindications: Patients having pregnancies of less than 15 weeks or more than 24 weeks gestation.

Warning: Inadvertent direct intravascular injection into highly developed vasculature of uterus and placenta should be avoided.

Dosage: 250 ml. maximum dose. See package insert.

Supplied: Solution, 250 ml.

New Dosage Forms

DARVON-N Suspension analgesic non-narcotic R

Manufacturer: Lilly

Nonproprietary name: Propoxyphene napsylate

Indications: For relief of mild to moderate pain

Contraindications: Hypersensitivity to drug. Do not give to children.

Dosage: 10 ml. three or four times a day

Supplied: Suspension, each 5 cc. contains 50 mg.

NAVANE Ataraxics

R

Manufacturer: Roerig

Nonproprietary name: Thiothizene hydrochloride

Indications: Acute schizophrenia

Contraindications: In patients with circulatory collapse, comatose states, central nervous depression due to any cause and blood dyscrasias.

Dosage: To be adjusted individually, maximum recommended dose 30 mg./day i.m.

Supplied: Vials, each cc. contains equivalent to 2 mg. of thiothizene.

ROBITET Syrup Broad spectrum antibiotic R

Manufacturer: Robins

Nonproprietary name: Tetracycline hydrochloride

Indications: See package insert

Contraindications: Hypersensitivity to any tetracyclines

Dosage: Adults 1 to 2 gms. divided into four equal doses

Children 24 to 50 mg./kg. of body weight divided into 4 equal doses.

Supplied: Syrup, each 5 cc. contains 125 mg.

Time to turn back the clock?

It's getting to be more of a compliment all the time to be told that we are trying to "turn back the clock" when we stand up for a solid, time-honored principle.

Some back-tracking would be good for us all.

The Chamber of Commerce of the United States observes that before jumping to conclusions it would be well to think how Grandpa probably would have reacted to suggestions that he give up blessings like these:

Respect for the flag, now replaced by the kind of acts and utterances that were once punished as treason.

Safety on the streets, so far gone that men may soon arm themselves to go to church, like the Pilgrim Fathers.

Discipline in the schools and order on the campuses.

Modesty in entertainment, instead of the lewdness and filth, to which we are now subjected.

Inspiration in literature, instead of chastisements for our "mass guilt."

Courtesy in salesmanship—the indifferent, snippy attitude of today's store clerks "is threatening to become the significant failure of American enterprise," according to Jack I. Strauss, R. H. Macy and Co.

Pride in craftsmanship, now given way to the mediocrity, featherbedding and fee-gouging prevalent in so many trades.

The right to spend one's earnings, instead of being forced to turn over an average 35% to tax collectors.

All in all, Grandpa may have preferred it like it was. And if the present social ailments get much worse, so may we. It's time to revive some old scruples, to rediscover the virtues of honest work, thrift, respect for authority and personal and community responsibilities.

If that requires turning back the clock, then, says the National Chamber, let's start turning.



HOME HEALTH CARE Is Our Specialty

DOCTOR: A MEDICAL EQUIPMENT UNLIMITED Pharmacy can provide the essentials needed to assist your patient in home convalescence or extended care. We deliver all items your patients require to their home on a sales or rental basis.

The following are some of the major items stocked: Convalescent Aids; walkers, wheel chairs, commodes, assist rails, canes, crutches. Orthopedic Equipment; back braces, trusses. Elastic Goods; compression hosiery, (custom fitted and custom made). Incontinent Aids; Exercise equipment, Inhalation equipment, Hospital beds, Colostomy, Osteotomy needs. **WE INVITE YOU** to investigate the services of an MEU Pharmacy by calling one of the following in your area:

CHICAGO

Adams-Woods Pharmacy
5258 West Fullerton
(237-0342)
Braun Pharmacy
2075 Lincoln Avenue
(LI-9-0634)
Bruce & Ken's Pharmacy
7150 West Addison
(685-6300)
Dodge Drug
3235 West 111th Street
(238-6686)
Elsdon Medical Pharmacy
4258 West 55th Street
(LU-2-2660)
Harding Pharmacy
3932 West Fullerton
(DI-2-9254)
Harry Ose Pharmacy
157 West 119th Street
(785-3984)
Lee Lincoln Pharmacy
6193 Lincoln Avenue
(539-1015)
Medical Care Pharmacy
2958 South Wallace
(225-6080)
P. F. Swanson Pharmacy
5259 North Clark Street
(LO-1-3222)
BERWYN
Havranek Pharmacy
6843 West Cermak Rd.
(ST-8-0175)
BROOKFIELD
Lonhart Pharmacy
9046 West 31st St.
(HU-5-2420)
DES PLAINES
Maple Pharmacy
1798 Oakton
(824-6191)

DOWNERS GROVE

Cameo Pharmacy
2752 Maple Avenue
(964-3784)

ELGIN

Munch's Civic Center Pharmacy
101 Douglas
(742-4277)

HOMewood

Niebert Pharmacy
2053 Ridge Road
(799-8552)

MOUNT PROSPECT

Van Driel's Pharmacy
100 East Northwest Highway
(CL-3-6494)

PARK FOREST

Needhams Pharmacy
23450 South Western Avenue
(747-0244)

ROCKFORD

Nowicki Pharmacy
1414 North Main
(815-962-4071)

WESTCHESTER

Nasek Apothecary
1925 Mannheim Road
(865-8900)

WESTMONT

Westmont Pharmacy
2 North Cass
(WO-9-2043)

WINNETKA

Conney Pharmacy
736 Elm Street
(446-3335)

WHEATON

Hawthorne Pharmacy
1425 N. Main Street
(MO-8-7600)

Clinics for February for crippled children

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will hold 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

February

- 2 Carlinville—Carlinville Area Hospital
- 3 Lake County Cardiac—Victory Memorial Hospital
- 4 Chicago Heights Cardiac—St. James Hospital
- 8 Peoria—St. Francis Children's Hospital
- 8 E. St. Louis—Christian Welfare Hospital
- 9 Hinsdale—Hinsdale Sanitarium
- 9 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
- 9 Champaign-Urbana—McKinley Hospital
- 10 Sterling—Sterling Community Hospital
- 10 Springfield—St. John's Hospital
- 10 Anna—Union County Hospital
- 15 Rock Island Area General—Moline Public Hospital
- 15 Belleville—St. Elizabeth's Hospital
- 16 Chicago Heights General—St. James Hospital
- 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 17 Bloomington—Mennonite Hospital
- 17 Rockford—St. Anthony Hospital
- 22 Peoria—St. Francis Children's Hospital
- 22 Danville—Lake View Hospital
- 23 Aurora—St. Joseph Mercy Hospital
- 23 Springfield Pediatric Neurological—Diocesan Center
- 25 Chicago Heights Cardiac—St. James Hospital
- 25 Evanston—St. Francis Hospital
- 28 Peoria Cardiac—St. Francis Children's Hospital
- 29 East St. Louis—Christian Welfare Hospital

For further information and locations, Phone (312) 921-5100.
A brochure is available.

Learn the new J C A H
****Accreditation Standards**
****Guidelines for Medical Staff Bylaws**
at
a Joint Commission on
Accreditation of Hospitals
Workshops

Thursday & Friday
April 6 & 7, 1972
Ramada Inn, Champaign

or

Wednesday & Thursday
April 12 & 13, 1972
LaSalle Hotel, Chicago

Each Workshop includes:

First Day . . . *

**New Rules for Governing Body &
Management . . . Medical Staff
. . . Medical Record Requirements
. . . Hospital Construction**

Guidelines for Medical Staff Bylaws

Second Day . . .

Physician Services























**Nursing, Pharmacy &
Environmental Services**

Medical Record Services

***Note:** Most staff physicians need attend only the first day. However, pathology and radiology-nuclear medicine standards are part of second-day program.

**Co-Sponsors: Illinois State Medical Society
Illinois Hospital Association**

**For details contact: PR Division, Illinois State Medical Society
360 N. Michigan Ave., Chicago 60601
312-782-1654**

 **SEVENTEENTH ANNUAL**
 **MEDICLINICS**
 **POSTGRADUATE MEDICAL**
 **REFRESHER COURSE**
 **MARCH 6-16, 1972**
 **Fort Lauderdale, Florida**
 **Headquarters: Galt Ocean**
 **Mile Hotel**
 **Sponsored by Florida**
 **Academy of General**
 **Practice and the Broward**
 **General Hospital. Accepted**
 **for 32 hours of credit by the**
 **American Academy of Gen-**
 **eral Practice.**
 **Registration information:**
 **MEDICLINICS**
 **832 Central Medical Building**
 **Saint Paul, Minnesota 55104**
 **Registration Fee: \$100.00 ..**
 **PRE-REGISTRATION HOTEL**
 **ROOM GUARANTEED**



**GIVE
 THE WORLD
 A HELPING
 HAND.
 MAIL YOUR CHECK.**

CARE - NEW YORK, N.Y. 10016 OR AREA OFFICES

the view box

(Continued from page 32)

Diagnosis: *Intraperitoneal rupture of the bladder.* Bladder injuries are produced either by external penetrating wounds, surgical procedures, non-penetrating blunt trauma such as occur with a distended bladder and spontaneous rupture.

In intraperitoneal rupture there is a tear in the bladder with communication to the peritoneal cavity. The diagnosis can either be made by means of a cystogram or intravenous pyelogram. The contrast material will appear in a smooth regular manner above the dome of the bladder which is the intraperitoneal portion of the bladder and it will then extend laterally on either side from the dome of the bladder in a band-like fashion. When bowel becomes encircled by the contrast media it will surround the bowel walls and the bowel will appear to float within the opaque media. This type of injury differs from an extraperitoneal rupture of the bladder where the contrast media is seen to spread in a rather streaky fashion along fascial planes. Perivesical hematomas cause the so-called teardrop bladder which is vertically elongated and narrowed and appears to be elevated from the symphysis pubis.

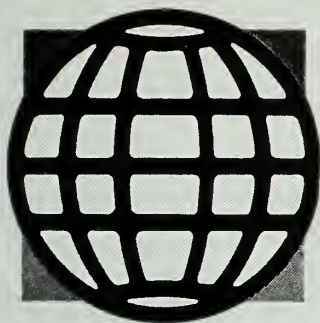
ekg of the month

(Continued from page 37)

Answers:

A. 4. Recent anterior wall myocardial infarction. QS waves are present in leads V_2 - V_4 . ST segments are elevated suggesting acute phase. If the segment elevation persists beyond 6 weeks, left ventricular aneurysm should be suspected.

B. 1, 2 & 4. Left ventricular failure is often difficult to diagnose in the face of acute myocardial infarction. Persistant S_3 after initial few hours is suggestive of the diagnosis. Digitalis will not always improve the left ventricular dysfunction. Diuretics may at times be helpful but hypovolemia produced by them should be avoided. The digitalizing dose should be reduced (half to two-thirds) because of the increased myocardial sensitivity to the digitalis during acute myocardial infarction.



socio-economic news

By JOSEPH J. LOTHARIUS

a service of the division of health care delivery

Are your assistant surgical Fees being paid?

Physicians billing insurance companies for assistant surgical fees may or may not be paid depending on whether such services are included in the contract coverage. Illinois Blue Shield reports assistant surgical coverage is a benefit not included in most of its present contracts. The company did say, however, several of its large group subscribers are requesting assistant surgical coverage in contract renewals. Other carriers, such as Continental Casualty Co., and Country Life Insurance of Bloomington said many of their present contracts do cover assistant surgical services. All carriers request that physicians bill assistant surgical fees separately. Such fees should not be included in the primary surgeon's charge. The carriers will reimburse each physician for the actual services rendered.

AMA delegates reaffirm Peer review goals

Health insurance carriers and government agencies were urged by AMA's House of Delegates to rely on peer review to resolve all issues requiring a professional judgment. AMA Delegates also reminded state and county medical societies of their responsibility to establish effective peer review mechanisms that are responsive to the needs of their respective communities. Delegates said the goal of peer review programs should be the improved quality of medical care and the more efficient delivery of medical services.

HASP begins In Chicago

Forty HASP (Hospital Admission & Surveillance Program) Coordinators began certifying lengths of stay for Medicaid patients in seven Chicago hospitals on January 15. The hospitals include Cook County, Illinois Masonic Medical Center, Michael Reese, Rush-Presbyterian-St. Lukes, Mercy, Mount Sinai and University of Chicago Hospitals & Clinic. Each of these institutions totaled more than 1,000 Medicaid hospital days in September, 1971, and thus qualified in the first implementation phase of HASP. The program coordinators, working under the supervision of physician advisors at every hospital, will certify all Medicaid hospital admissions using the Professional Activities Study (PAS) as the base point for determining lengths of stay.

A 50th birthday celebration is coming...

FOR SOME PHYSICIANS' wives the Roaring 20's may seem only yesterday. Others have no memory at all of these exuberant days since they were not yet born. But all doctors' wives are celebrating in 1972 the founding of the organization that is peculiarly theirs—The Woman's Auxiliary to the American Medical Association.

In May 1922, doctors and their wives headed towards St. Louis for the annual convention of the AMA. Among them were a group of determined women from Texas intent upon forming a national organization of physicians' wives "to extend the aims of the medical profession."

A resolution was presented to the AMA House of Delegates requesting AMA approval of a "Woman's Auxiliary to the AMA." The physicians passed the resolution and on May 26, 24 physicians' wives from nine states got together in Room 118 of the Statler Hotel. They emerged at noon to announce the birth of the new organization.

Today the AMA Woman's Auxiliary numbers nearly 90,000. Members are committed to the task of raising the level of health care in the United States.

At its convention in Atlantic City in June, 1971, the auxiliary presented the AMA Education and Research Foundation with a check for \$550,927.01. This was the largest single contribution ever received by AMA-ERF for educational purposes. It brought a total of nearly eight million dollars that physicians' wives have donated to the foundation in the past 20 years.

In addition to raising funds for AMA-ERF, the members of the Illinois Auxiliary contribute generously to the Benevolence Fund which aids disabled physicians and their families in Illinois.

The medical auxiliary is an action-oriented organization and the action begins in the county



auxiliary with the individual members. Physicians' wives as a whole are a busy group. Members throughout the United States are involved in hundreds of community projects providing help for the elderly, the dependent, the delinquent, educating youth, and lending helping hands wherever needed.

In San Francisco next June, members of the AMA Woman's Auxiliary will observe the 50th anniversary of the auxiliary with a grand celebration. The week's events highlight the accomplishments of the auxiliary over the past 50 years and trace the expansion of its programs and projects.

A 50-year history of the national auxiliary is now being completed for publication (\$2.00 a copy from AMA Auxiliary, 535 N. Dearborn, Chicago). Charm bracelets, note pads and note paper bearing the special 50th anniversary seal will also be available for sale to benefit the American Medical Association Education and Research Foundation.

Auxiliary's Package Programs have a new look!

NEW THINGS HAVE been happening to the medical auxiliary's package programs. They are being re-edited, updated and simplified.

Those available to all county auxiliaries for use are: Alcohol, Block Mother Plan, Drug Abuse, Health Manpower, Immunization, Sex Education, Smoking, Teen-age Venereal Disease and Physical Fitness.

New programs are being developed on Mental Health for Children and Homemaker Services.

Kits available are Blood Donor and GEMS (Babysitter Training Course).

Write to auxiliary headquarters at 535 N. Dearborn St., Chicago, Ill., 60610 for a copy of any program your auxiliary wishes to use.

Obituaries

Edward Allen, Walnut Creek, Calif., formerly of Chicago, died July 19, at the age of 79.

Raymond E. Baxter, Bloomington, died October 27, at the age of 63. He was in practice as a physician and surgeon in Bloomington for nearly 27 years before assuming the county post as state health official.

****John E. Boland**, Palm Beach, Fla., a retired Chicago physician and surgeon, died October 28, at the age of 80.

Homer Meade Buckner, Dodgeville, Wis., formerly of Chicago, died August 5, at the age of 85.

****Stephen M. Burdon**, Lowpoint, died November 11, at the age of 81. He retired in 1967 after practicing medicine for 53 years.

****Samuel J. Burrows**, died November 6, at the age of 75. He was a Chicago physician and surgeon for 54 years and the founder of the former Burrows Hospital.

***Walter Dalitsch. Sr.**, Lake Bluff, died November 30, at the age of 73.

****Otto E. Fink**, formerly of Danville, died in Santa Monica, Calif. November 4, at the age of 89. He was a retired physician.

George Goldenberg, Chicago, died October 28, at the age of 65. He practiced in the Hyde Park area for 29 years and served as the coroner's physician on the South Side for the past 25 years.

****Michael C. Goy**, Chicago, died November 16.

J. A. Havens, Lincoln, died October 16. He was a physician for 60 years.

****Harry Isaacs**, Chicago, died November 16, at the age of 77. He was a physician here for more than 50 years.

***Walter R. Ketterer**, Breese, died November 7, at the age of 66. He was a practicing physician for 31 years.

Abraham J. Kosman, Chicago, died November 30, at the age of 60. He taught at the Northwestern Medical School for 28 years.

***Howard M. Luce**, Skokie, died November 10, at the age of 42.

John Marino, Lincolnwood, died October 15, at the age of 51.

William G. Reeder, Wheaton, died November 28, at the age of 93. He practiced in Wheaton and Chicago for 44 years.

***Jerome B. Reich**, Chicago, died November 7, at the age of 61. He was president of Grant Hospital medical staff and a practicing physician for 35 years.

***Harold Shellow**, Chicago, died November 23, at the age of 57. He was a professor of dermatology at the University of Illinois Medical School and past president of the Chicago Dermatological Association.

***Susan Slakis**, Homewood, died November 7.

***Herbert M. Smulson**, Evanston, died November 12, at the age of 53.

***Arthur Stenn**, Chicago, died November 10, at the age of 67. For 40 years he served as a field doctor for the County Board of Public Welfare and the Chicago Board of Health. He was known as the "Bicycle Doctor" since he made house calls on a bicycle.

John A. Weideman, Villa Park, died October 30, at the age of 53.

***Henry I. Zayas**, Oak Park, died November 11, at the age of 55.

**Member of ISMS*

***Fifty year club member*

More savvy than cents

How much more do savings earn when interest is compounded quarterly instead of once a year? Less than most depositors think. **Scientific American** bared these facts in its "Mathematical Games" column:

At a simple annual rate of 4%, without compounding, \$1 will double itself in 25 years. Compounded annually, over the same period, the \$1 becomes \$2.66 plus. If compounded semi-annually, it will earn 3¢ more in the 25 years and become \$2.69 plus.

Compounding monthly or daily—or even every minute—adds very little. A mathematical limit is reached before another 3¢ is added, and the total will never exceed \$2.71 plus in 25 years of compounding at any frequency whatever.

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®

(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

© 1972 The Upjohn Company

Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia. During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemo-



what goes on

a guide to continuing education

January 7, 14, 21 & 28—Alfred Adler Institute

"Four Workshop Sessions in Psychodrama"

These four classes will be organized to meet the training of the participants, either for hospital, classroom, or community use. One quarter credit is offered for this workshop. Fee: \$50 for all four sessions. Group is limited to 15. For additional information and registration write: Mrs. Evelyn Wachman, Executive Secretary, Alfred Adler Institute, 110 S. Dearborn St., Chicago, Ill. 60603 or call (312) 346-3458.

Alfred Adler Institute, Chicago, Ill.

January 18—Chicago Committee on Trauma of the American College of Surgeons

"Musculo-Skeletal and General Surgery Trauma"

The program will cover the following topics: Multiple Injuries from Elevator Fall; The Unconscious Unidentified Patient; Loading Dock Accident with Fracture and Vascular Injury of Lower Extremity; Electrical Injury; Pelvic Fracture; and Stab Wound of

Chest and Abdomen. The program will be held from 8 to 10 p.m. Physicians attending the meeting may be reached at WH4-4200. All physicians are invited.

Passavant Memorial Hospital, 303 E. Superior Street, Chicago

January 21-22—Arizona Heart Association

"Annual Cardiac Symposium"

Speakers on program include: Eugene Braunwald, M.D.; Nina S. Braunwald, M.D.; Thomas N. James, M.D.; and Andrew G. Wallace, M.D. For information write: Arizona Heart Association, 1720 E. McDowell Road, Phoenix, Arizona 85006

Mountain Shadows Resort Hotel, Phoenix, Arizona

January 22—Alfred Adler Institute

"Behavior Problems of Children"

This course focuses on understanding behavior and correcting misbehavior. The Adlerian procedures in diagnosis, encouragement, reorientation, logical consequences, and group procedures are featured. The course methodology features lecture, small group discussion, the discussion of critical incidents, and demonstrations. For further information and registration write: Alfred Adler Institute, 110 S. Dearborn St., Chicago, Ill. 60603 or call (312) 346-3458.

Midland Hotel, 172 W. Adams, Chicago, Ill.

January 23—Alfred Adler Institute

"The Fundamentals of Adlerian Psychology"

Perception and Apperception. Value as a goal. Selectivity: Its function in the Service as a Goal. Faulty and Non-Faulty Values; The "Measuring Sticks." Influence on the Life Style, Physical Factors; Developmental Factors; Cultural Factors. For further information write: Alfred Adler Institute, 110 S. Dearborn St., Chicago, Illinois 60603 or call (312) 346-3458.

Midland Hotel, Chicago, Ill.

January 23-29—American Academy of Facial Plastic and Reconstructive Surgery, Inc.

"Concepts of Soft Tissue Surgery"

The workshop is designed to cover the fundamentals of soft tissue surgery in the region of the head and neck. Illustrated lectures, television tapes and movies form the basic material. Participants will be encouraged to present problem cases for discussion by the faculty. Registration fee: \$400. For further information contact: John T. Dickinson, M.D., D. Sc., G-2 M.D. Building, 1501 Locust St., Pittsburgh, Pa. 15219.

Mercy Hospital, Pittsburgh, Pa.

January 26—Illinois Psychiatric Society

"Annual Dinner Meeting"

Cocktails at 6 and dinner at 7. Guest speaker: John

Romano, M.D., professor of psychiatry at Rochester University. Topics discussed will be: "The Psychiatrist—What Is He to Become?" Fee: \$13. Reservations must be made no later than Jan. 21. For further information write: Illinois Psychiatric Society, 211 E. Chicago Ave., Chicago, Ill. 60611.

Sheraton-Chicago, Chicago

January 26-28 — Northwestern University Medical Center and Passavant Memorial Hospital

"Postgraduate Course in Internal Medicine"

Subjects discussed will include: especial current interest in hematology, oncology, the collagen diseases, cardiovascular disease, endocrinology and gastroenterology. Registration fee: \$90. For information write: "The Year in Internal Medicine", Passavant Memorial Hospital, 303 E. Superior St., Chicago, Ill. 60611

Offield Auditorium, Passavant Memorial Hospital, Chicago, Ill.

January 27-30—Medical College of Wisconsin

"2nd Annual Winter Refresher Course for Family Physicians"

The four-day course will include review and discussion of medical topics of particular interest to family physicians, and a practice exam for doctors intending to take the family practice board examination. The course is approved for 24 hours of prescribed credit by the American Academy of Family Physicians. Registration is limited to 100 participants. For further information contact: Mrs. Elaine Gamberdinger, Continuing Education Department, Medical College of Wisconsin, 561 N. 15th St., Milwaukee, Wisconsin 53233

Pfister Hotel and Tower, Milwaukee, Wisconsin

January 27-29—American College of Chest Physicians

"Respiratory Function and Therapy"

For information write: American College of Chest Physicians, 112 E. Chestnut St., Chicago, Ill. 60611

Los Angeles, Calif.

February 2—University of Missouri-Columbia Medical Center

"Office Pediatrics"

This course will give physicians who care for children an opportunity to discuss with members of the pediatric staff some current, practical aspects of the outpatient care of children. For information write: University of Missouri-Columbia, School of Medicine, Committee for Continuing Medical Education, M-175 Medical Center, Columbia, Mo. 65201

February 2-3—Cleveland Clinic Foundation

"General Practice"

February 8—Chicago Committee on Trauma of the American College of Surgeons

"General Surgery Trauma"

All physicians are invited. The meeting will begin at 8 p.m., and a general surgery meeting will also be held at this time.

Illinois Masonic Hospital and Medical Center, 834 W. Wellington, Chicago

February 9-10—Cleveland Clinic Foundation

"Thyroid Disease and Disorders of Calcium Metabolism"

For additional information write: Director of Education, The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio 44106.

February 9—University of Chicago, Division of the Biological Sciences and the Pritzker School of Medicine

"Modern Concepts in Cervical Cancer"

This program will concentrate on two problems arising from the widespread use of cytologic screening for cancer of the cervix. Cases will also be presented which illustrate special problems in management of this type of cancer. For information and registration write: "Frontiers of Medicine," The University of Chicago, (BH Box 451) 950 E. 59th St., Chicago, Illinois 60637

Frank Billings Auditorium, University of Chicago, Chicago, Ill.

February 6-11—American Academy of Facial Plastics and Reconstructive Surgery, Inc.

"Rhinoplasty Workshop"

Course will include lectures; color television will be used to include live and tape productions of surgical techniques. Includes patient selection; analysis; photography; anaesthesia; dorsum management, tip surgery; osteotomies; septal surgery; post operative care; grafts and implants; nasal fractures; profile plasty and mentoplasty and complications. Registration fee: \$150. For further information write: Mrs. Caroline Flynn, Division of Post Graduate Medicine, University of Toronto, Toronto, Ontario, Canada

University of Toronto, Toronto, Canada

February 14-16—American College of Surgeons

Features will include: trauma reports, nutrition in adults and infants; a current gynecology program which will include a panel on carcinoma of the cervix and on chronic pelvic pain. For information write: American College of Surgeons, 55 E. Erie St., Chicago, Ill.

Chase-Park Plaza Hotel, St. Louis, Mo.

(Continued on page 92)

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages**, (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for

the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

T. R. Van Dellen, M.D., Editor
Illinois Medical Journal
360 N. Michigan Ave.
Chicago, Ill. 60601.

APPROVED

AVAILABLE NOW!

ISMS

MALPRACTICE INSURANCE

**Professional Liability Insurance
Program**

**Approved for Members
REGARDLESS of AGE
or SPECIALTY**

Protect Doctor's Integrity

Company will settle no claims without insured member's approval. Nuisance claims will be fought.

Improve Legal Climate

Company will retain outstanding defense counsels who are experts in professional-liability cases.

Provide Market Stability

Company will maintain an available market. Participation by the members is needed to assure this market.

Keep Members Informed

Company will tell members how to prevent claims . . . keep them aware of latest legal developments in malpractice field.

ISMS Supervision And Control

Premiums to reflect only the loss experience of ISMS. All questionable underwriting cases to be reviewed by ISMS. A UNIQUE FEATURE

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT ADMINISTRATORS:

PARKER, ALESNAIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000



"My secret?
For heartburn I always
use 'Dicarbosil'."

Dicarbosil[®]
ANTACID
Write for Clinical Samples
ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

COOK COUNTY Graduate School of Medicine

CONTINUING EDUCATION COURSES
STARTING DATES—1972

SPECIALTY REVIEW COURSE FOR FAMILY PRACTICE, January 31
SPECIALTY REVIEW COURSE IN UROLOGIC PATH. & X-RAY,
Feb. 3 & 4
SPECIALTY REVIEW COURSE IN SURGERY, Part II, February 14
SPECIALTY REVIEW COURSE IN MEDICINE, Part II, February 14
SPECIALTY REVIEW COURSE IN NEUROLOGY, Basic, April 3
SPECIALTY REVIEW COURSE IN PEDIATRICS, April 17
REVIEW COURSE IN NEUROPATHOLOGY, April 10
SPECIALTY REVIEW COURSE IN THORACIC SURGERY, April 17
STATE & NATIONAL BOARD REVIEW, Basic, April 9
STATE & NATIONAL BOARD REVIEW, Clinical, April 17
MANAGEMENT OF COMPLICATIONS IN SURGERY 4 Days, March 7
PRE & POSTOPERATIVE CARE OF PATIENTS, 4 Days, March 14
SURGERY OF THE GASTROINTESTINAL TRACT, One Week, April 10
NEWER UROLOGIC INSTRUMENTATION, One Day, March 20
ADVANCES IN UROLOGY, Two Days, March 14
PEDIATRIC UROLOGY, Two Days, March 16
VAGINAL APPROACH TO PELVIC SURGERY, One Week, Feb. 7
BASIC ELECTROCARDIOGRAPHY, One Week, March 6
BASIC INTERNAL MEDICINE, One Week, March 20

*Information concerning numerous other continuation
courses available upon request.*

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

What goes on

(Continued from page 90)

February 15-18—University of Iowa

"Four-Day Refresher Course for the Family Practitioner"

Brief lectures, small group discussions, question and answer periods, lunch with experts, self-instructional demonstrations, printed course syllabus, clinical films, pre-conference self-assessment quiz—are all designed to provide a fast moving and educational experience. For registration and information write: Director, Office of Medical Education, Office of the Dean, The University of Iowa, Iowa City, Iowa 52240

University of Iowa Health Center, Iowa City,
Iowa

February 16-17—University of Missouri-Columbia Medical Center

"Orthopedic Conference"

This two-day conference is designed to review for the practicing physician some of the basic problems in the management of common fractures and to bring them up-to-date on any new developments. For information write: University of Missouri-Columbia, School of Medicine, Committee for Continuing Medical Education, M-175 Medical Center, Columbia, Mo. 65201

February 23—Cleveland Clinic Foundation

"Learning Disabilities and the Physician"

For information write: Director of Education, The Cleveland Clinic Foundation, 2020 E. 93rd St., Cleveland, Ohio 44106.

February & March—Illinois Academy of Family Physicians

"Medicine for Today"—Postgraduate Program

The program will consist of a series of correlated lectures on the following topics by teachers pre-eminent in their fields:

- *Medicine and Rehabilitation
- *Modern Concepts in OB-GYN
- *The Patient with Increased Blood Pressure
- *Sports Medicine

This program is acceptable for 30 prescribed hours by the American Academy of Family Physicians. Registration for the entire course: Members \$75; non-members \$85. A list of locations, registrars and dates and times can be acquired by writing to the Illinois Academy of Family Practice Physicians, 14 E. Jackson Blvd., Chicago 60604.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

New National Reciprocity System— Improved Claims Service for Physicians

A new nationwide system of payment has been developed by the National Association of Blue Shield Plans to provide direct and immediate payment to physicians when they treat patients who are members of another Blue Shield Plan. Called the "Reciprocity System", the program becomes effective March 1, 1972, and will enable Illinois physicians to bill and receive payment directly from the Blue Shield Plan of Illinois Medical Service for services provided to out-of-state subscribers having this *special contract*.

Payment under the Reciprocity System will be made on a 100% Usual and Customary basis. This means that a physician will receive 100% of his usual fee when this fee is "within the range of usual fees charged by physicians of similar training and experience" for services covered under the Reciprocity agreement. Because the claim will be processed by Illinois Medical Service without any delay for membership verification, the physician will receive payment promptly.

Blue Shield subscribers participating in the program will be easily identified by Illinois physicians and medical assistants by a special identification card which carries a double-pointed red arrow in the upper left corner. A series of three numbers preceded by the letter "N" appear within this red arrow. This number indicates the "Home Plan" of the subscriber. (See sample identification card below.)

When a physician treats a patient having this special card, he files for Blue Shield benefits in the same manner as he would for an Illinois member with ONE exception. Both the letter "N" and the code numbers within the red arrow AND the subscriber's identification number should be entered in the group and subscriber number box on the Physician's Service Report form. This enables our claims examiners to identify readily the claim as a Reciprocity System claim and to allow us to coordinate with the Home Plan *after* payment is made.

The Reciprocity System offers many advantages to Illinois physicians:

1. Payment is guaranteed. As long as the necessary and correct identifying information is recorded on the Physician's Service Report, the claim can be processed and payment made to the physician.

2. No contact with another Blue Shield Plan or filling out an unfamiliar Blue Shield form is necessary. Claims are submitted to Illinois Medical Service using our own Physician's Service Reports.

3. No longer will the physician have to wait for payment while another Plan contacts Illinois Medical Service about medical charges in our area. We can make payment promptly using the physician's fee data we have collected and have on record.

4. The patient is fully covered for a wide range of services. These include surgery, wherever performed, anesthesia, radiation therapy, in-hospital X-ray and laboratory services consistent with the diagnosis, in-hospital medical care not related to surgery or maternity care, outpatient emergency medical and emergency accident care, and consultations.

The program *does not cover* maternity services, dental or nursing services, appliances and supplies, services primarily for diagnostic reasons, Workmen's Compensation cases and claims for Medicare beneficiaries. (A more detailed list of covered and noncovered services will be published in a future issue.)

Below is an example of a Reciprocity System identification card. Note the double-pointed arrow. If you have any questions regarding the card, claim filing or benefits, contact your Professional Relations Representative or call the Professional Relations Department—(312) 661-4594.



BLUE SHIELD®		NATIONAL ACCOUNT	
IDENTIFICATION CARD			
N 123		F2	
SUBSCRIBER		CODE	
60609	1024756	03	1 72
GROUP	IDENTIFICATION	MO. DAY YEAR EFFECTIVE	

CONCURRENT MEDICAL CARE DEFINED

When a patient is admitted to the hospital primarily for surgical or obstetrical care, additional benefits for concurrent medical care rendered by a physician other than the surgeon or obstetrician would be paid by Blue Shield "only in unusual instances where specialized medical care is essential to and distinct from the surgical or obstetrical care". See our November 1971 issue for further clarification.

ASK BLUE SHIELD

ABOUT MEDICARE

Part B Coverage for Nursing Home Visits

Payment to physicians under Part B Medicare for treatment of patients in a nursing home is governed by special regulations issued by the Social Security Administration.

According to these regulations, Medicare payment can be made for only *one* physician visit to the same patient in a nursing home in a calendar month, on the presumption that such a visit is medically necessary for a person whose condition requires him to reside in the home. Payment for additional visits to a specific patient can be made only when the physician substantiates the medical necessity of such visits.

When only one patient is visited, payment will not exceed the maximum allowance available for a routine follow-up house call. Also, no additional charges for travel will be allowed unless "extraordinary circumstances" are indicated.

Visits scheduled by a physician to *all* his patients in a nursing home once per month would be allowable. When more than one patient is seen in a nursing home, payments will not exceed the customary allowance for routine follow-up office visits.

Unless otherwise indicated on the Medicare claim or itemized statement, the Part B Medicare carrier has to assume that a claim for a visit to a nursing home included more than one patient and will make payment on that basis.

When completing a claim form or itemized statement, the Social Security Administration suggests that you indicate "only patient seen" or "special visit—acute" plus the appropriate medical justification for such a visit. A description of the medical condition, such as "acute abdominal pain" or "acute febrile episode", is often more informative than a diagnosis. This information will help us make payments correctly and promptly.

For additional information, contact your Professional Relations Representative or the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601.

SSA Certifies New Laboratories

The following laboratories have been certified for Medicare participation by the Social Security Administration:

Cytodiagnostic Laboratory
25 East Washington Street
Chicago, Illinois 60602

26th Street Medical Center Laboratory
3814 West 26th Street
Chicago, Illinois 60623

Allergy Treatment Benefits

A recent revision of the Part B Intermediary Manual by the Social Security Administration now indicates the circumstances under which payment can be made for allergenic extracts. Such coverage would be available under the drugs and biologicals provisions of the Part B benefits.

When an allergist prepares and charges the patient for an allergenic extract, payment can be made for the extract only if the allergist also administers it. Similarly, if the extract is administered by another physician, it would be covered only if the administering physician obtains the extract from the allergist and the cost of the extract is included in the administering physician's itemized statement to the patient. In instances where the allergist charges the patient for the extract but another physician administers it, payment can be made for the administration of the extract but not for the extract itself.

Billing for allergy treatments which are provided over an extended period may be made by one statement for all treatments or by periodic statements, i.e., monthly or quarterly. When billing periodically, it should be remembered that charges for services are considered incurred under the Medicare program at the time they are actually performed. Charges for anticipated services are not considered incurred under the program.

Therefore, the SSA 1490 should be submitted only after the last treatment included on the bill has been given or, when billing for all treatments provided during one calendar year, after the end of that calendar year.

In addition, services included in one statement which are performed prior to the beginning of a patient's coverage or after his coverage has ended are not considered incurred under the Medicare program and will be excluded from coverage.

ITEMIZED STATEMENTS NEEDED

"Request for Payment" forms or bills submitted to Medicare (Blue Shield for Cook County) must be completely itemized. An itemized bill includes the diagnosis, date of each service, the place of service, the charge for each service and the type of service rendered.

However, there is an exception to this ruling. Because of the difficulty in breaking out the charge for the tests included in a Profile Test, we will accept bills giving the total charge for the Profile Test, the date the tests were given, the name of each test in the group and the diagnosis.



illinois medical journal

volume 141, number 2

February, 1972

staff	editor	Theodore R. Van Dellen, M.D.
	managing editor	Richard A. Ott
	assistant editor	Michaelyn Sloan
	advertising manager	John A. Kinney
	executive administrator	Roger N. White

convention	Delegates Handbook	129
	Resolutions	188
	Program Summary by Days	206

surgical grand rounds	Adrenal cyst	212
--------------------------	--------------------	-----

features	the presidents page	106
	clinics for handicapped children	124
	the view box	211
	ekg of the month	215
	editorials	216
	practice management	219
	trauma center	222
	socio-economic news	229
	new pharmaceutical specialties	232
	what goes on	234
	obituaries	237
	pulse of the doctor's wife	238
	imaa report	241

Cover art by George Brownlee

"The Gross Clinic"

Thomas Eakins 1844-1916

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601. Copyright, 1972, The Illinois State Medical Society.

Subscription \$5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$7.50 per year for all foreign countries included in the Universal Postal Union. Canada \$5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.



REGISTERED



MEDIA DATA FORM

When irritable colon feels like this





IENTS CAN BE
UCCESSFULLY
INTAINED ON A
UG CONTAINING
YROXINE ALONE.

roxine (T_4) is, as you know,
major circulating hormone
uced by the thyroid gland.
also produced, in smaller
nts, and is active at the
ar level. For years it has been
aking hypothesis among
crinologists that T_4 is
verted by the body to T_3 . In
this process, called
dination," was demonstrated
averman, Ingbar, and Sterling².
es convert to T_3 , though the
se quantities are still being
ed.

conversion has been
ally demonstrated during the
istration of T_4 to athyrotic
nts. Their thyroid status is
alized on SYNTHROID alone,
the presence of T_3 in these
nts has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3 ?

Very simple. T_3 costs more to make
synthetically than does T_4 . So it is
economically necessary for a
synthetic thyroid medication
containing T_3 to cost more than
one containing T_4 alone. Synthetic
combinations cost patients nearly
50% more than SYNTHROID³
because the T_3 costs more to start
with; also there is the additional
expense of formulating a tablet
containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of
Prescription Medications by Outpatients,
Drug Intelligence & Clin. Pharm. 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and
Sterling, K.: Conversion of Thyroxine (T_4) to
Triiodothyronine (T_3) in Athyreotic Human
Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

Synthroid[®]

(sodium levothyroxine)

FACTS ARE
AR AND HERE
OUR OFFER.

TS:
netic thyroid drugs are an
ovement over animal gland
ucts. Patients, even athyrotic
can be completely
tained on SYNTHROID (T_4)
Thyroid function tests are
to interpret since they are
ctably elevated when the
nt adheres to SYNTHROID.
synthetic thyroid drugs,
HROID is the most
omical to the patient.

OFFER:

Free TAB-MINDER medication
dispensers to start or convert all
your hypothyroid patients to
SYNTHROID. Free information to
physicians on role of thyroid
function tests in a new booklet
titled: "Guideposts to Thyroid
Therapy." Ask us.

Name _____

Address _____

City _____

State _____

Zip _____

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for Injection is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.



FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Morton Grove, Illinois 60053



the presidents page

"Seven Come Eleven!"

Convention time nears

Now remember this:

"SEVEN COME ELEVEN!" Why? Because...

... You take our own ISMS Annual Meeting, add Chicago Medical Society's Midwest Clinical Conference (one of the best anywhere), then mix in scientific programs by no less than 18... that's right, EIGHTEEN specialty societies, and you have...

... Convention '72 on March 7 come 11 at Chicago's Conrad Hilton Hotel!

So mark the dates on your appointment calendar... and DO IT NOW! Join your colleagues and their families at what promises to be the greatest medical meeting ever held in Illinois.

You'll find a diversified choice of superb post-graduate and instructional courses, lectures, symposiums, panel discussions, scientific films, special programs and exhibits.

Special day-long courses and seminars in surgery, obstetrics and gynecology, pediatrics, internal medicine and emergency room trauma procedures will be held.

And don't miss the opportunity to examine more than 150 scientific and technical exhibits. Look in and see your own ISMS House of Delegates in action. The House will convene Tues-

day, March 7, to consider matters affecting YOUR medical future.

There will be something for your wife too. The Auxiliary has planned many excellent educational and entertaining activities. And of course there are a number of fine stores in Chicago for her shopping pleasure, not to mention restaurants and cultural attractions.

Numerous other programs and activities are scheduled, including the President's Dinner, the annual Public Affairs Dinner, and special programs by ISMS Councils and Committees.

All this year... during my tenure as President... I have talked long and loud about unity, and the individual responsibility of each and every one of us to work together to find new medical horizons.

Certainly Convention '72 is a fine example of what unity and cooperation can do. Combining the 132nd ISMS Annual Meeting and Chicago Medical Society's 28th Annual Midwest Clinical Conference benefits YOU as well as the two societies. You need attend only one major medical meeting, rather than two as in past years.

The promise of a record attendance means that specialty societies and exhibitors will go all out to make a fine showing.

Why don't YOU make a showing too!

Remember! In March it's... SEVEN COME ELEVEN!

L. J. Friedman

"Doctoring" yourself

"Millions of Americans would benefit more from changing their dietary habits, losing weight, exercising, stopping cigarette smoking and cutting down or ending their consumption of alcohol and other drugs than from having more physicians and more hospitals available to treat them after their bad habits laid them low." (Harry Schwartz: "Too Few Doctors?," N. Y. Times, June 28, 1971.)

ALL IN HIS HEAD:

Watery Eyes

Nasal
Congestion

Sneezing

Runny Nose

**THE COLD
SYMPTOMS
THAT
MAKE HIM
MISERABLE**

ALL IN 'ORNADE:

Drying Agent
(isopropamide,
as the iodide—
2.5 mg.)

Decongestant
(phenylpropanol-
amine HCl—50 mg.)

Antihistamine
(chlorpheniramine
maleate—8 mg.)

**THE
INGREDIENTS
HE NEEDS
FOR PROLONGED
RELIEF**

Before prescribing, see complete prescribing information in SK&F literature or PDR.

Indications: Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Advise vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness, or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

SK&F Smith Kline & French Laboratories

Trademark

ORNADE® SPANSULE®

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

brand of sustained release capsules

UNCOMMON RELIEF FOR COLD SYMPTOMS

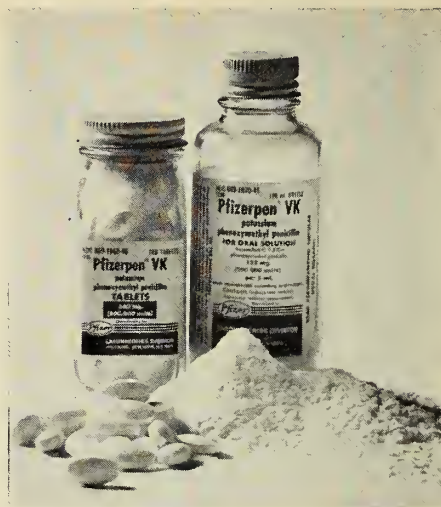
Schedule of clinics for handicapped

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will hold 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

March—

- 1 Hinsdale—Hinsdale Sanitarium
- 1 Carmi—Carmi Township Hospital
- 2 Sterling—Sterling Community Hospital
- 2 Springfield—St. John's Hospital
- 2 Effingham—St. Anthony Memorial Hospital
- 2 DuQuoin—First Methodist Church
- 2 Lake County Cardiac—Victory Memorial Hospital
- 8 Joliet—St. Joseph's Hospital
- 8 Champaign-Urbana—McKinley Hospital
- 9 Macomb—McDonough District Hospital
- 10 Chicago Heights Cardiac—St. James Hospital
- 14 Peoria—St. Francis Children's Hospital
- 14 Carrollton—Boyd Memorial Hospital
- 14 E. St. Louis—Christian Welfare Hospital
- 15 Evergreen Park—Little Company of Mary Hospital
- 15 Jacksonville—Norris Hospital
- 16 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 16 Decatur—Decatur Memorial Hospital
- 21 Rock Island Area General—Moline Public Hospital
- 21 Belleville—St. Elizabeth's Hospital
- 22 Elgin—Sherman Hospital
- 22 Springfield Pediatric Neurological—Diocesan Center
- 22 Rockford—St. Anthony Hospital
- 22 Centralia—St. Mary's Hospital
- 24 Chicago Heights Cardiac—St. James Hospital
- 27 Peoria Cardiac—St. Francis Children's Hospital
- 28 Peoria—St. Francis Children's Hospital
- 28 Alton—Alton Memorial Hospital

PFIZERPEN DOSAGE FORMS



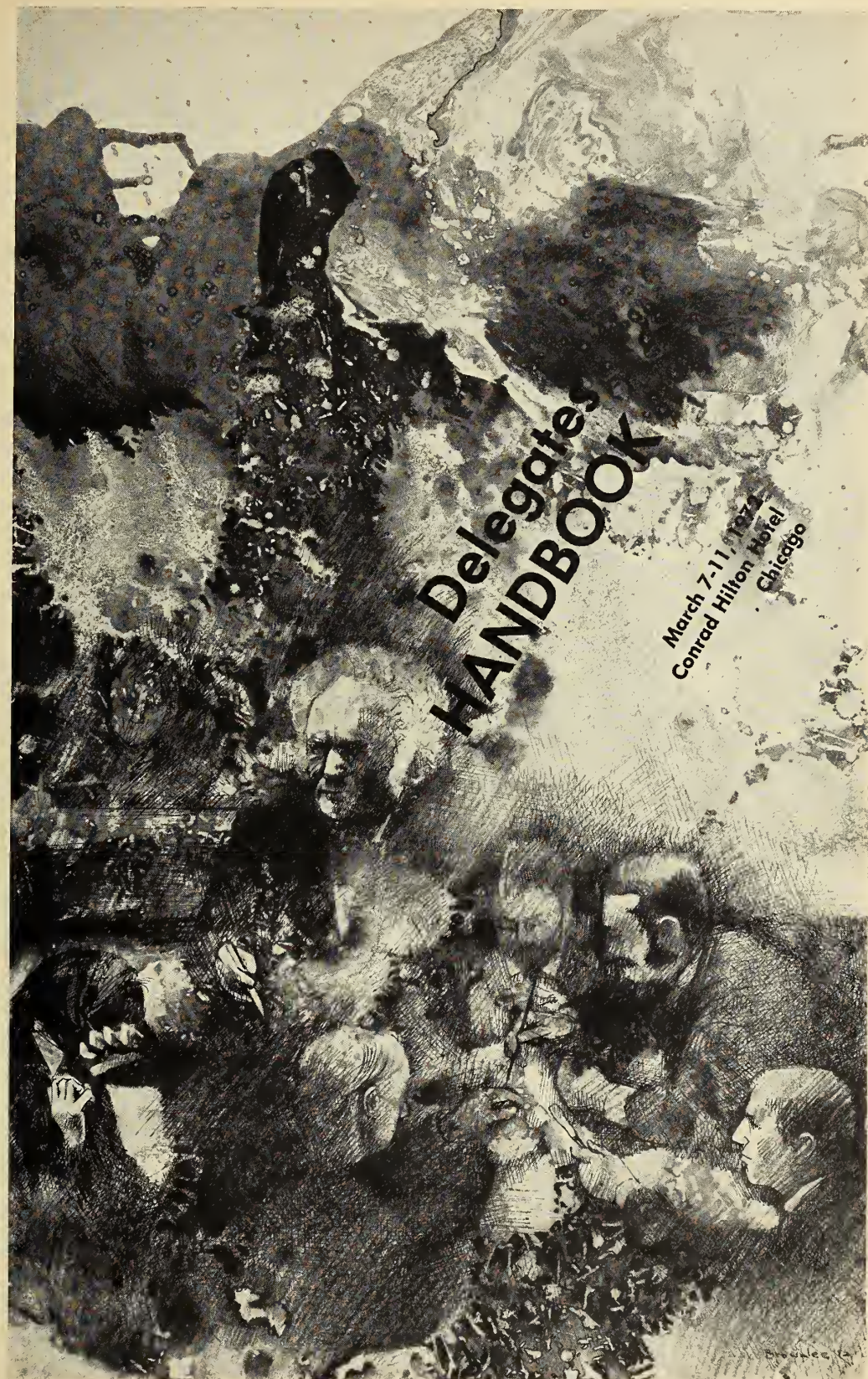
**Orange-flavored
Pfizerpen VK for Oral Solution**
(potassium phenoxymethyl penicillin)
125 mg. (200,000 units)/5 cc.:
bottles of 100 cc. and 150 cc.
250 mg. (400,000 units)/5 cc.:
bottles of 100 cc. and 150 cc.

Pfizerpen VK Tablets
(potassium phenoxymethyl penicillin)
250 mg. (400,000 units): bottles of 100.
500 mg. (800,000 units): bottles of 100.



**Butterscotch-caramel-flavored
Pfizerpen G Powder for Syrup**
(potassium penicillin G)
400,000 units/5 cc.:
bottles of 100 cc. and 200 cc.

Pfizerpen G Tablets
(potassium penicillin G)
200,000 units: bottles of 100 and 500.
250,000 units: bottles of 100.
400,000 units: bottles of 100 and 1000,
and unit-dose pack of 100 (10 x 10's).
800,000 units: bottles of 100.



Delegates HANDBOOK

March 7-11, 1972
Conrad Hilton Hotel
Chicago

INDEX

HOUSE OF DELEGATES

Agenda	134
Board of Trustees	131
Committees	136
Delegates and Alternates	132
Ex-Officio Members	131
Officers	131

OFFICERS AND ADMINISTRATION

President	138
President-Elect	138
First Vice-President	139
Second Vice-President	139
Trustee Reports	
First District	140
Second District	140
Third District	140
Fourth District	140
Fifth District	140
Sixth District	141
Seventh District	141
Eighth District	141
Ninth District	141
Tenth District	141
Eleventh District	142
Trustee-at-Large	142
Chairman of the Board	142
Speaker of the House of Delegates	143
Vice-Speaker	144
Executive Administrator	144
AMA Delegation	144
President of the Woman's Auxiliary	146
Committees of the Board of Trustees	
Advisory Committee to the Woman's Auxiliary	147
Committee on Constitution and Bylaws	147
The Educational & Scientific Foundation	147
Committee on Health Care Financing	148
Committee to Study Osteopathic Problems	148
Policy Committee	148
Publications Committee	148
Editorial Board	150
Editor <i>Illinois Medical Journal</i>	150
Task Force on Comprehensive Health Planning	151
Task Force on Physician Shortage and Services to Medically Deprived Areas	151

ECONOMICS AND PEER REVIEW

Council on Economics and Peer Review	153
Committee on Drugs and Therapeutics	157

EDUCATION AND MANPOWER

Council on Education and Manpower	158
---	-----

ENVIRONMENTAL AND COMMUNITY HEALTH

Council on Environmental and Community Health	161
---	-----

FINANCES AND BUDGETS

Secretary-Treasurer	168
Committee on Benevolence	173

GOVERNMENTAL AFFAIRS

Governmental Affairs Council	174
------------------------------------	-----

MEDICAL-LEGAL

Medical-Legal Council	178
Ethical Relations Committee	179

MENTAL HEALTH AND ADDICTION

Council on Mental Health and Addiction	180
--	-----

PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Council on Public Relations and Membership Services	185
--	-----

SOCIAL AND MEDICAL SERVICES

Council on Social and Medical Services	187
--	-----

SPECIAL REPORTS

Illinois Department of Children and Family Services	165
Illinois Department of Mental Health	182
Illinois Department of Public Aid	153
Illinois Department of Public Health	164
Illinois Division of Vocational Rehabilitation	155
Resolutions	188
Program Summary by Days	206
Postgraduate Courses	208

Members of the 1972 House of Delegates

OFFICERS

President	L. T. Fruin
President Elect	Frank J. Jirka, Jr.
Secretary-Treasurer	Jacob E. Reisch
Speaker of the House	Paul W. Sunderland

TRUSTEES

First District	Joseph L. Bordenave	1974	Fourth District	Fred Z. White	1973
Second District	Allan L. Goslin	1974	Fifth District	A. Edward Livingston	1973
Third District	Wm. M. Lees	1974	Sixth District	Mather Pfeiffenberger	1972
	Eugene T. Hoban	1972	Seventh District	Arthur F. Goodyear	1973
	Warren W. Young	1972			
	Fredric D. Lake	1972	Eighth District	Eugene P. Johnson	1973
	Robert T. Fox	1973	Ninth District	Charles K. Wells	1972
	David S. Fox	1973	Tenth District	Willard C. Scrivner	1972
	Frederick E. Weiss	1973	Eleventh District	Joseph R. O'Donnell	1974
	George Shropshear	1974			
	Philip G. Thomsen	1974	Trustee-at-Large	J. Ernest Breed	

EX OFFICIO

(Privilege of the floor but without the right to vote)	
1st Vice President	C. J. Jannings, III
2nd Vice President	William E. Adams
Vice Speaker (when not presiding)	Andrew J. Brislen

Past Presidents

J. Ernest Breed	1971	Willis I. Lewis	1954
Edward W. Cannady	1970	George F. Lull	1963
Everett P. Coleman	1945-46	Burtis E. Montgomery	1966
Newton DuPuy	1968	Edward A. Piszczek	1965
Harlan English	1964	Caesar Portes	1967
Edwin S. Hamilton	1962	Leo P. A. Sweeney	1953
H. Close Hesseltine	1961	Philip G. Thomsen	1969
James H. Hutton	1940	Arnell M. Vaughn	1955

Delegates to AMA

Carl E. Clark	Maurice M. Hoeltgen	Edward A. Piszczek
Jack L. Gibbs	Joseph R. Mallory	Harold A. Sofield
Theodore Grevas	Morgan M. Meyer	Philip G. Thomsen
H. Close Hesseltine		Francis W. Young

Past Trustees or Councilors

William E. Adams	Third District	George A. Hellmuth	Third District
Earl H. Blair	Third District	Bernard Klein	Eleventh District
Walter C. Bornemeier	Third District	Ted LeBoy	Third District
Carl E. Clark	First District	William A. McNichols, Jr.	Second District
Newton DuPuy	Sixth District	Warner H. Newcomb	Sixth District
Willard W. Fullerton	Tenth District	Ralph N. Redmond	Second District
George E. Giffin	Second District	Wm. H. Schowengerdt	Eighth District
Lee N. Hamm	Fifth District	Darrell H. Trumpe	Fifth District
James B. Hartney	Third District	Paul P. Youngberg	Fourth District

Delegates and Alternate Delegates to the Illinois State Medical Society

DOWNSTATE DELEGATES

County	Delegate	Alternate	County	Delegate	Alternate
ADAMS	James Sutherland	Lucius Hollister, Jr.	MACON (2)	M. D. Murlin	C. G. Glenn
ALEXANDER	Paul A. Spence	Charles Yarborough		C. L. Sandburg	A. J. Kiessel
BOND	Boyd McCracken	M. K. Kaufman	MACOUPIN	Lee Johnson	R. H. Rutherford
BOONE	M. J. Carlisle	Adrian Schreiber	MADISON (2)	Edward DuVivier	James Adams
BUREAU				George T. Wilkins	George F. Dietz
CARROLL	E.M. Colli	Cecil G. Piper	MARION	Walter P. Plassman	W. W. Davidson
CASS-BROWN	B. A. Desulis	J. J. Hea	MASON	Jack Means	Dario Landazuri
CHAMPAIGN (2)	Harold J. Kolb	James M. Laidlaw	MASSAC	George Green	E. Yap
	C. H. Walton	Homer A. Hindman	McDONOUGH	V. B. Adams	Donald H. Dexter
CHRISTIAN	R. G. Siegert	R. M. Seaton	McHENRY	George Alvary	Edward Chereck
CLARK	George Mitchell	James R. Buechler	MCLEAN	Paul Theobald	Loren Boon
CLAY	<i>Not sending delegates</i>		MENARD	Paul M. Purdy	Robert Schafer
CLINTON	M. A. Batemann	W. L. DuComb	MERCER	Monty P. McClellan	R. N. Svendsen
COLES-	Joseph R. Mallory	M. W. Hollowell	MONROE	Edilberto Maglasang	Joseph Werth
CUMBERLAND			MONTGOMERY	Rudolf Sommer	Wm. T. Douglas
CRAWFORD	C. M. Maples	W. B. Schmidt	MORGAN-SCOTT	Robert R. Hartman	E. C. Bone
DEKALB	John Ovitz	John Ladd	MOULTRIE	<i>Not sending Delegates</i>	
DEWITT	Charles A. Ramey	Herman L. Meltzer	OGLE	Robert Dearborn	Don Hinderliter
DOUGLAS	Walter G. Steiner	Grant A. Jones	PEORIA (3)	G. W. Gielbehausen	Fred J. Heinzen
DUPAGE (5)	Morgan M. Meyer	John V. Ryan		Willard M. Easton	Robert A. DeBord
	J. P. Campbell	Charles G. White		Hugh J. McMenamin	John W. Berney
	Wm. E. Hill	Ronald M. Severino	PERRY	C. E. Cawvey	James Stotlar
	Ralph G. Ryan	Wm. B. Frymark	PIATT	George G. Green	Marion D. Kinzie
	Wm. C. Perkins	Lily Ann Palmer	PIKE	Meyer Shulman	Gene Goodman
EDGAR	J. M. Ingalls	Charles Salesman	PULASKI	A. L. Robinson	Marvin F. Powers
EDWARDS	Andrew Krajec	Paul S. Neirenberg	RANDOLPH	O. W. Pflasterer	J. M. Whittenberg
EFFINGHAM	Ernest Frank	Frederick Reiss	RICHLAND	C. A. DeKovessey	John S. Dunker
FAYETTE	S. W. Moore	Hans Rollinger	ROCK ISLAND (2)	Theodore Grevas	George H. Burke
FORD	Ross H. Hutchison	Edson L. Etherton		C. P. Cunningham	Wm. Dogherty
FRANKLIN	John P. Pope	James P. Durham	ST.CLAIR (3)	Julian Buser	Charles R. Frazer
FULTON	J. L. Gibbs	R. E. Reinertsen		John S. Hipskind	Peter J. Soto
GALLATIN	W. F. Stanelle	Joe Bryant		H. Frank Holman	Dale Rosenberg
GREENE	James C. Reid	Jude A. Casellton	SALINE-POPE-	Warren D. Tuttle	Earl Walker
HANCOCK	Charles Eddingfield	Byron Mueller	HARDIN		
HENDERSON	Silvino C. Lindo, Jr.	Harold Bock	SANGAMON (3)	William W. Curtis	G. K. Greening
HENRY-STARK	James C. Parsons	William D. Larson		Earl D. Donelan	Homer M. Kimmich
IROQUOIS	R. K. Swedlund	James Dailey		Edward G. Ference	Henry F. Rohs
JACKSON	W. R. Malony	Lelan E. Stallings	SCHUYLER	Henry C. Zingher	Robert Cox
JASPER	<i>Not sending Delegates</i>		SHELBY	Duncan Biddlecomb	C. A. Spears
JEFFERSON-	Crile Doscher	Antonio Boba	STEPHENSON	E. L. Vickery	Jaime Ballesteros
HAMILTON			TAEZEWELL	Erik Maran	N. A. Wright, III
JERSEY-	Bernard Baalman	Ferdinand Gorecki	UNION	R. L. Rader	W. H. Whiting
CALHOUN			VERMILION	A. M. Taylor	J. L. Gulick
JO DAVIESS	Kris Gudaitis	Francis B. Waites	WABASH	Roger Fuller	Donald Risley
KANE (3)	Robert G. Stone	Ronald J. Winters	WARREN	Russell Jensen	Richard Icenogle
	James A. McDonald	Gerald J. Liesen	WASHINGTON	Jerry L. Bequelin	Charles Longwell
	Wayne N. Leimbach	Peter Starrett	WAYNE	C. J. Jannings, Ill.	Edward Talaga
KANKAKEE	D. L. Learned	D. L. Hegg	WHITE	P. D. Boren	William Courtage
KENDALL	Walter H. Brill	Joseph L. Daw	WHITESIDE	John F. Hubbard	E. J. Roubicek
KNOX	John J. Holland	H. L. Fleisher Jr.	WILL-GRUNDY	Robert J. Becker	F. Roger Fahrner
LAKE (4)	John J. Ring	Lionel Ganshirt	(3)	Guy A. Pandola	John H. Kendall
	David Helberg	Richard Hawkins		Barry S. Seng	George J. Honiotes
	Earl Klaren	Richard Dolan	WILLIAMSON	Herbert V. Fine	
	Eugene Pitts	John Andrews	WINNEBAGO (4)	Robert E. Heerens	R. J. Rosenberg
LA SALLE	William Erkooen	T. Wagenknecht		E. T. Leonard	D. P. Feehey
LAWRENCE	R. C. Kirkwood	Gilbert Miller		F. H. Riordan III	Robert A. Behmer
LEE	Edward S. Murphy	Charles H. Lesage		Donald H. Wrook	Robert D. Weber
LIVINGSTON	Theodore Mauger	Karl Deterding	WOODFORD	Hans W. Riggert	Roland J. Davies
LOGAN	Gilbert E. Blaum	James B. Borgerson		STUDENT AMERICAN	
				MEDICAL	David Lark
				ASSOCIATION	Michael Greenberg

CHICAGO MEDICAL SOCIETY

Delegates

Alternate Delegates

Delegates

Alternate Delegates

AUX PLAINES BRANCH

John S. Hyde	Allison L. Burdick, Jr.
Chester B. Thrift	Robert C. Muehrcke
William Ashley	Matthew Platt
C. Otis Smith	Meredith B. Murray
Joseph B. Moles	Martin W. Green
Roland Kowal	Arthur G. Lawrence
Allison L. Burdick, Sr.	Gustav A. Hemwall
Everett E. Nicholas	Richard H. Blankshain

CALUMET BRANCH

Eugene F. Diamond	Thaddeus C. Fial
Stanley E. Ruzich	Paul M. Blackburn
Robert E. Lee.	Nestor S. Martinez

DOUGLAS PARK BRANCH

Edward A. Razim	Donald Meizo
Colman J. O'Neill	Robert F. Cesafsky
Loren B. Horton	Robert H. MacNerland
Charles Mrazek	Gilbert R. DeMange
Raymond Nemecek	Miles Cermak

ENGLEWOOD BRANCH

Edward Krol	John Krolikowski
Frank Kwinn	Joseph Patka
F. Saletta	Kosme Kapov
William Nainis	John Meyer
Nathan Pitaro	John Dudek

NORTH SUBURBAN BRANCH

Leon L. Ampel	Harley Sigmond
Richard Stalzer	Carl Johner
Philip Sheridan	Myles P. Cunningham
William J. FitzPatrick	Jerome T. Paul
John W. O'Donnell	George A. McDermott
Howard C. Burkhead	James Holland
David W. Cromer	Thomas G. Soper
C. Malcolm Rice, Jr.	John M. Bailey
John L. Savage	Thomas Stafford
James W. Ford	James R. Dillon

IRVING PARK SUBURBAN BRANCH

Herman Wing	Theodore Johnson
Eugene Broccolo	Sanford Franzblau
Lawrence Hirsch	Thomas Conley
Martin P. Meisenheimer	George W. Holmes
Allen Hrejsa	Alexander Ruggie
George C. Turner	A. Clementi
Arthur T. Haebich	Earl Solon
Vincent C. Sarley	Philip H. Heller
Alfred J. Faber	Peter Pleotis

JACKSON PARK BRANCH

Julius E. Ginsberg	Daniel J. Pachman
David S. Fox	Mathew W. Kobak
Loran H. Dill	Henrietta Herbolzheimer
Myron M. Hipskind	Harry J. Hunter
Murry M. Paull	William P. Mavrelis

NORTH SHORE BRANCH

Philip R. McGuire	H. Kenneth Scatliff
Herschel Browns	Samuel T. Gerber
George C. Markoutsas	Lief Bjornssen
Joseph R. DeCaro	Rudolph W. Roesel
William O. Ackley	William B. Stromberg, Jr.
Rocco V. Lobraico	Frank Hussey
John B. Murphy	Jack D. Clemis
David T. Petty	Steven J. Spinuzza
George H. Irwin	Arthur R. Peterson
Burton J. Soboroff	Danford Chamberlain
Clarence A. Norberg	Joseph H. Skom

NORTH SIDE BRANCH

Vincent C. Freda	Richard Perritt
Jack Williams	Benjamin F. Lounsbury
Erwin M. Patlak	I. Pat Bronstein
Clifton L. Reeder	Joseph Schifano
James P. FitzGibbons	Lydia Nikurs
Michael H. Boley	Joseph C. Sherrick
Roland R. Cross	Daniel Ruge
Samuel L. Andelman	C. Larkin Flanagan
William A. Hutchison	Bernard T. Peele
Coye C. Mason	Ray Silins

NORTHWEST BRANCH

I. P. Lombardo	John M. Smialek
Alfred A. Zanette	John V. Fowler
Louis A. Wajay	Alfonso Diaz
E. J. Kotanyi	N. J. Kupferberg
Michael J. Kutza	M. A. Rydelski

SOUTH CHICAGO BRANCH

Arne E. Schairer	Anthony G. Cesare
Morris T. Friedell	Jere Freidheim
Simon Y. Saltman	Maynard I. Shapiro

SOUTH SIDE BRANCH

Kermit T. Mehlinger	Otto J. Keller
Alfred Klinger	Jacob M. Epstein
Robert R. Mustell	Aldo Pedroso

SOUTHERN COOK COUNTY BRANCH

Herbert E. Fisher	C. R. Heidenreich
Roberto Sarmiento	Robert VanEtten
Charles O. Sandberg	Aaron Heimbach

STOCK YARDS BRANCH

Edwin J. Lukaszewski	Frank J. Nowak
----------------------	----------------

WEST SIDE BRANCH

Eugene T. Hoban	William J. Tansey
Anna Marcus	Henry B. Okner
J. Robert Thompson	Louis S. Varzino

AT-LARGE

Andrew J. Brislen
Charles J. Weigel
Charles P. McCartney
Fredric D. Lake
A. Everett Joslyn

Agenda

1972 House of Delegates

Paul W. Sunderland, *Speaker*

Andrew J. Brislen, *Vice-Speaker*

FIRST SESSION

3:00 p.m., Tuesday, March 7, 1972

Contrad Hilton Hotel—Chicago

1. Call to Order by the Speaker—Paul W. Sunderland
2. Invocation—Rabbi Mordecai Simon
3. Report of Credentials Committee—Roll Call
Edward DuVivier, Charles P. McCartney,
Co-Chairmen
4. Report of Committee on Rules and Order of
Business—Edward A. Razim, *Chairman*
5. Approval of the minutes of the May, 1971, meeting
of the House of Delegates (Abstracts enclosed in
packet for members of the House)
6. Memorial Service for deceased members since May,
1971—Conducted by Jacob E. Reisch, *Secretary*
7. Introduction of special guests
President, WOMAN'S AUXILIARY TO ISMS
Mrs. David Kweder
President, ILLINOIS SOCIETY, AMERICAN ASSOCIATION
OF MEDICAL ASSISTANTS
Miss Jean Berschinski
Officers of other medical societies
L. T. Fruin, *President*
8. Introduction of new delegates
Paul W. Sunderland
9. Introduction of AMA Delegates and Alternates from
ISMS
H. Close Hesseltine, *Chairman of Delegation*
10. Presentation of AMA-ERF Check
L. T. Fruin, *President*
11. Report from IMPAC (Illinois Medical Political Action
Committee)
V. P. Siegel, *Chairman*
12. The President's Address
L. T. Fruin, *President*
13. Report of Executive Administrator
Roger N. White
14. Presentation of Special Awards
15. Remarks of Speaker
Paul W. Sunderland
16. Appointment and changes of Reference Committees
17. Introduction of Resolutions
18. Introduction of Supplementary Reports
19. Introduction of Late Resolutions
20. New Business—Announcements
21. Recess until 2 p.m., Thursday, March 9, 1972

SECOND SESSION

2:00 p.m., Thursday, March 9, 1972
Conrad Hilton Hotel—Chicago

1. Call to order by the Speaker—Paul W. Sunderland
2. Invocation—Rev. Harold Kamenz
3. Roll Call-Credentials Committee
Edward DuVivier, Charles P. McCartney
Co-Chairmen
4. Report-Committee on Rules & Order of Business
Edward A. Razim, *Chairman*
5. Announcements
Scientific Exhibit Award
Harold A. Sofield, *Chairman*
6. Introduction-Guests and Visitors
L. T. Fruin, *President*
7. Reports of Reference Committees
 - a. Constitution & Bylaws
C. P. Cunningham, *Chairman*
 - b. Officers & Administration
George Alvary, *Chairman*
 - c. Finances, Budgets & Publications
Herschel Browns, *Chairman*
 - d. Governmental Affairs
J. P. Campbell, *Chairman*
 - e. Education and Manpower
John S. Hyde, *Chairman*
 - f. Environment, Community, and Mental Health
David Petty, *Chairman*
 - g. Economics, Peer Review, Social and Medical Services
Robert J. Becker, *Chairman*
 - h. Public Relations & Miscellaneous Business
Vincent C. Sarley, *Chairman*
8. Unfinished Business
9. New Business-Announcements
10. Recess until 10. a.m., Friday, March 10, 1972

THIRD SESSION

10:00 a.m., Friday, March 10, 1972
Conrad Hilton Hotel—Chicago

1. Call to order by the Speaker—Paul W. Sunderland
2. Invocation—Father John Marren
3. Roll Call-Report of Credentials Committee
Edward DuVivier, Charles P. McCartney
Co-Chairmen
4. Report-Committee on Rules & Order of Business
Edward A. Razim, *Chairman*
5. Induction of Frank J. Jirka, Jr., *President-Elect*, into office of President, by L. T. Fruin, *Retiring President*
6. Remarks of the President
Frank J. Jirka, Jr.
7. Introduction of guests and visitors
8. Presentation of awards
9. Reference Committees-presentation of remaining reports
10. Elections
 - Report of Nominating Committees
 - a. President-Elect (Downstate)
 - b. 1st Vice President (Chicago)
 - c. 2nd Vice President (Downstate)
 - d. Secretary-Treasurer (Downstate)
 - e. Speaker of the House (Downstate)
 - f. Vice Speaker (Chicago)
 - g. Trustees

<i>District</i>	<i>Terms Expiring</i>
3rd	Eugene T. Hoban
3rd	Fredric Lake
3rd	Warren W. Young
6th	Mather Pfeifferberger
9th	Charles K. Wells
10th	Willard C. Scrivner
 - h. Delegates to AMA-to take office Jan. 1, 1973 and serve to Dec. 31, 1974
Terms expiring:
Carl E. Clark
H. Close Hesseltine
Maurice M. Hoeltgen
Joseph R. Mallory
Francis W. Young
 - i. Alternate delegates to AMA-to take office Jan. 1, 1973 and serve to Dec. 31, 1974
Terms expiring:
Frank J. Jirka Jr.
Joseph R. O'Donnell
Fred A. Tworoger
Theodore R. Van Dellen
John Ring
 - j. Election of alternates to fill any other unexpired terms resulting from prior elections
11. Unfinished business
12. New Business
 - a. Fixing of the per capita assessment for 1973, based upon the recommendation of the Board of Trustees
 - b. Selection of the meeting place for 1973.
 - c. Election of Emeritus, Retired members and those whose dues have been cancelled for cause
 - d. Other
13. Adjournment, *sine die*

1972 Committees of the House of Delegates

COMMITTEE ON CREDENTIALS

Edward DuVivier, *Co-Chairman* (DS)
Charles P. McCartney, *Co-Chairman* (CMS)
Herman Wing (CMS) Charles DeKovessey (DS)
Rocco V. Lobraico (CMS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House on Tuesday and one-half hour prior to the opening of the other two sessions.
Standby:

Jacob Epstein (CMS) Eugene Pitts (DS)
Julius Ginsberg (CMS) John Pope (DS)

COMMITTEE ON RULES & ORDER OF BUSINESS

Edward A. Razim, *Chairman* (CMS)
Stanley A. Ruzich (CMS) James Reid (DS)
Edwin Lukaszewski (CMS) V. B. Adams (DS)

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the sessions of the House of Delegates. It shall work in close co-operation with the Speaker and the Vice-Speaker

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.
Standby:

Roberto Sarmiento (CMS) Robert R. Mustell (CMS)
Theodore Mauger (DS) Clarence E. Cawvcy (DS)

TELLERS & SERGEANTS AT ARMS

James Parsons, *Chairman* (DS)
Alfred Zanette (CMS) W. Malony (DS)
George Turner (CMS) W. G. Steiner (DS)
This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot vote is scheduled, or the House goes into executive session.
Standby:
Joseph M. Moles (CMS) John L. Savage (CMS)
Jack Means (DS)

REFERENCE COMMITTEE ON GOVERNMENTAL AFFAIRS & MEDICAL-LEGAL

J. P. Campbell, *Chairman* (DS)
Arne E. Schairer (CMS) E. G. Ference (DS)
Henrietta Herbolzheimer (CMS) Julian W. Buser (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON GOVERNMENTAL AFFAIRS
Public Affairs Committee
Eye Committee
Ear, Nose & Throat Health Committee

MEDICAL-LEGAL COUNCIL
Impartial Medical Testimony
Laboratory Services
Licensure

TASK FORCE, COMPREHENSIVE HEALTH PLANNING
Standby:

Leon Ampel (CMS) Alfred Faber (CMS)
Ross N. Hutchison (DS) Donald Wrock (DS)

REFERENCE COMMITTEE ON ECONOMICS, PEER REVIEW, SOCIAL & MEDICAL SERVICES

Robert J. Becker, *Chairman* (DS)
Charles Weigel (CMS) John Ovitz (DS)
Clifton Reeder (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON ECONOMICS & PEER REVIEW
Advisory to the Division of Vocational Rehabilitation
COUNCIL ON SOCIAL & MEDICAL SERVICES
Aging
Nursing
Rehabilitation Services
Hospital Relations—Ad Hoc
COMMITTEE ON DRUGS AND THERAPEUTICS
ILLINOIS FOUNDATION FOR MEDICAL CARE
DIRECTOR: ILLINOIS DEPT. OF PUBLIC AID
DIRECTOR: ILLINOIS DEPARTMENT OF VOCATIONAL REHABILITATION

Standby:
William F. Ashley (CMS) James W. Ford (CMS)
R. C. Kirkwood (DS) John Holland (DS)

REFERENCE COMMITTEE ON EDUCATION AND MANPOWER

John S. Hyde, *Chairman* (CMS)

Eugene F. Diamond (CMS) John Ring (DS)
Frank L. Hussey (CMS) John Hubbard (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON EDUCATION & MANPOWER

Advisory to SAMA
Allied Health Education
Continuing Education
Student Loan Fund

Standby:

Raymond Nemecek (CMS) Allison Burdick, Sr. (CMS)
Ralph G. Ryan William Curtis (DS)

REFERENCE COMMITTEE ON ENVIRONMENTAL, COMMUNITY & MENTAL HEALTH

David Petty, *Chairman* (CMS)

Joseph H. Skom (CMS) Dale Learned (DS)
J. Robert Thompson (CMS) Robert Hartman (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON ENVIRONMENTAL & COMMUNITY HEALTH

Child Health
Maternal Welfare
Nutrition
Public Safety

COUNCIL ON MENTAL HEALTH & ADDICTION

Alcoholism
Narcotics

DIRECTOR: DEPARTMENT OF PUBLIC HEALTH

DIRECTOR: DEPARTMENT OF MENTAL HEALTH

Standby:

Daniel Pachman (CMS)
Samuel Andelman (CMS)

REFERENCE COMMITTEE ON FINANCES, BUDGETS & PUBLICATIONS

Herschel L. Browns, *Chairman* (CMS)

Murry M. Paull (CMS) James McDonald (DS)
Philip R. McGuire (CMS) G. W. Giebelhausen (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

TREASURER

BENEVOLENCE COMMITTEE

EDUCATIONAL & SCIENTIFIC FOUNDATION

PUBLICATIONS COMMITTEE

EDITORIAL BOARD

THE BUDGETS prepared and approved by the Board and submitted for the information of the House

THE AUDIT of Society accounts for the year 1971 as ordered by the Bylaws (By Peat, Marwick & Mitchell)

Standby:

Clarence Norberg (CMS) Vincent Freda (CMS)
Guy Pandola (DS) James Sutherland (DS)

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

C. P. Cunningham, *Chairman* (DS)

Howard C. Burkhead (CMS) J. M. Ingalls (DS)
Lawrence Hirsch (CMS) Wayne Leimbach (DS)

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution & Bylaws.

Standby:

A. Everett Joslyn (CMS) William A. Hutchison (CMS)
Hugh J. McMenamin (DS) William Hill (DS)

REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND ADMINISTRATION

George Alvary, *Chairman* (DS)

Jere E. Freidheim (CMS) Alan Taylor (DS)
C. Otis Smith (CMS) Paul Theobald (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

PRESIDENT

PRESIDENT ELECT

1ST VICE PRESIDENT

2ND VICE PRESIDENT

SECRETARY

CHAIRMAN OF THE BOARD

TRUSTEES FROM THE ELEVEN TRUSTEE DISTRICTS

TRUSTEE-AT-LARGE

SPEAKER OF THE HOUSE

VICE SPEAKER OF THE HOUSE

CHAIRMAN—AMA DELEGATION

EXECUTIVE ADMINISTRATOR

PRESIDENT—WOMAN'S AUXILIARY TO ISMS

BOARD COMMITTEES:

ADVISORY COMMITTEE TO THE AUXILIARY

Policy Committee

Committee on Committees

Committee to Study Osteopathic Problems

Standby:

Anna Marcus (CMS) Burton Soboroff (CMS)
Earl Klaren (DS) H. Kolb (DS)

REFERENCE COMMITTEE ON PUBLIC RELATIONS, MEMBERSHIP & MISCELLANEOUS BUSINESS

Vincent C. Sarley, *Chairman* (CMS)

Joseph R. DeCaro (CMS) Maurice Murfin (DS)
Morris T. Fridell (CMS) Warren Tuttle (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the reports of the following committees and upon any other matters referred by the Speaker

COUNCIL ON PUBLIC RELATIONS & MEMBERSHIP SERVICES

Medicine & Religion

Insurance

TASK FORCE ON PHYSICIAN SHORTAGE &

SERVICES TO MEDICALLY DEPRIVED AREAS

Standby:

Eugene Leonard (DS) R. K. Swedlund (DS)
Roland Kowal (CMS) Louis Wajay (CMS)

Officers and Administration

PRESIDENT

As president of your Illinois State Medical Society during the past year, a major goal was to bring to the lay public a new understanding of the problems and promises of Illinois medicine . . . to tell OUR side of the health care story to anyone who would listen . . . and to stimulate in myself . . . and you . . . a renewed sense of unity and purpose for the difficult times ahead.

President's Tour: The format for the President's Tour was changed this year. Emphasis was placed on appearances before county medical societies throughout Illinois. At each stop, civic club appearances and interviews at newspapers and radio and TV stations were scheduled whenever possible. I addressed more than two thousand physicians and lay people in stops at Carbondale, Granite City, Rock Island, St. Charles, Champaign, Freeport, Peoria, Springfield, Casey, Belleville, LaSalle, Kankakee and Wheaton. Our story reached thousands more through publicity generated in the news media.

Other Meetings: I also attended a meeting of the Philippine Medical Association of Chicago on September 18, 1971, the Kentucky Medical Association in Louisville on September 23-24, the American Medical Association's Clinical Session in New Orleans November 28-December 1, the AMA annual meeting in Atlantic City, June 20-24, and the ISMS Doctor's Job Fair in Chicago on October 24.

The meeting with our Philippine-born colleagues was especially satisfying since ISMS was successful in securing state legislative approval of a bill allowing foreign-born physicians to practice in Illinois up to five years before securing U.S. citizenship. Many of these physicians are now practicing in various cities throughout Illinois, certainly a welcome addition to our ranks.

Newspaper Series: My Community Health Week theme for last year was alcoholism, a number one health problem in Illinois. A four-part newspaper series was reprinted in more than 100 Illinois newspapers, both dailies and weeklies throughout the state.

Summation: During the President's Tour, on my regular "President's Page" in the *Illinois Medical Journal*, and at other meetings, I crusaded for changes in our health care system through evolution . . . not revolution! We must seek to preserve the traditional freedoms enjoyed by both patient and physician under the private practice of medicine.

But there is also room for innovative approaches to health care delivery systems, approaches such as our own Illinois Foundation for Medical Care. The Foundation will offer packaged health care programs, but we physicians will retain control of these programs, not government health care planners.

Most of all, I have stressed the need for physicians to quit talking to each other, and to talk to the public . . . to tell OUR side of the health care story . . . to counter our critics by putting health care costs in the proper perspective. Time after time in my travels lay people told me they'd like to hear from us more often.

We must talk to the public . . . we must support our county and state medical societies and the AMA . . . we must participate in programs such as the Governmental Affairs Council's Key Man program, which led to the most successful legislative year ever enjoyed by this society. If our present system of medicine is to endure and grow stronger, then we must all do our part.

It has been a busy year, and sometimes a tiring one. But it was a worthwhile year, certainly. I am gratified to have been chosen to bring our message to thousands of people in Illinois. I would also like to extend my "Thank You" to the Board of Trustees, officers and staff . . . and to all my colleagues, who have done so much to help me.

L. T. Fruin

PRESIDENT ELECT

Since my election as President Elect of the Illinois State Medical Society, I have been privileged to work for you in many activities. In addition, it has been a distinct pleasure to meet with and serve with the members of the Board of Trustees and my fellow officers. The mutually supportive role of these many dedicated individuals can do nothing but better the climate for the medical profession in Illinois. In briefly reviewing some of my activities during the past months, I would cite the following, not to the exclusion of many others.

At the Illinois Hospital Association Meeting in Arlington Park, it was my pleasure to stand-in for President Fruin.

Serious discussion has evolved regarding health facility planning legislation. In trying to resolve differences of opinion between the hospitals and the physicians, I have been serving on an Ad Hoc Committee.

HASP, Hospital Admission and Surveillance Program, a new acronym which came on the scene on 1971, occupied much of my time. This is a very important development for the medical profession and I hope to intensify my efforts in this during my coming year.

A speakers bureau was established recently by the AMA to furnish resource persons to discuss Medi-Credit with interested groups. It has been my pleasure to be a part of that activity.

Liaison with the Blues has been another concern. Hopefully we will be able, by mutually beneficial discussion, to resolve some of the differences occurring between carriers and physicians.

Additional paramedical personnel are needed to support the physician in the private practice of medicine in Illinois. An Ad Hoc Committee has been formed, in collaboration with the Illinois Hospital Association, to study the licensure or certification problems inherent with the increase in paramedical personnel categories. I am seriously concerned with this and am happy to be working with this group.

Other activities in which I have been engaged would be as a consultant to several Councils and Committees of ISMS, an alternate delegate to the AMA, as well as now being an attendee at the meeting of state society presidents.

My hopes and aspirations for 1972 will be outlined in my inaugural address to the House of Delegates at the Annual Meeting. I look forward to the cooperation of the membership in carrying forth the goals of improving the health and well being of the people of Illinois through improvement of the environment in which physicians practice.

Frank J. Jirka, Jr.

FIRST VICE PRESIDENT

Perhaps the most exciting development in the past year was recognition by the University of Illinois School of Medicine of their responsibility to train family doctors for the people of Illinois by appointing Dr. Glen Tomlinson as Head of the Department of Family Practice at Lincoln School of Medicine; also the recognition by Cook County Hospital of the necessity of providing post-graduate training for physicians in the specialty of Family Practice. In addition, the U of I Medical School has informed the Student Loan Fund Board that they now could recommend *any* number of candidates (previously limited to ten, then later to twenty) all of whom would be considered by the University's Admission's Committee. Southern Illinois University School of Medicine's rapid progress is heartening.

Your first vice-president: (1) served as consultant to the Council on Governmental Affairs and commends the action of this council for its zealous pursuit of organized medicine's position in Springfield. This year we were saddened by the unexpected and accidental death of Timothy Selleck.

2) Attended the annual meeting of the Indiana State Medical Association in Indianapolis at the request of President Fruin. Dr. Wesley Hall, President of the AMA, addressed the Indiana House of Delegates and appealed for participation in organized medicine by researchers and teachers and public health physicians. He appealed for unity in the face of increasing pressures from third parties.

3) Participated in deliberations of the Ad Hoc Committee to study the concept of the physician's assistant and strongly recommends that P.A.'s be certified and limited at present to assisting physicians in the active private clinical practice of primary medicine.

4) Attempted to bring home the fact that an expansion in the supply of physicians engaged in the primary care areas must precede any expansion of promises for medical care made by third parties. Failure to do this will result in higher costs, disappointed patients, and increased controls over the practice of medicine in the United States.

5) Actively debated Illinois Regional Medical Program health planning proposals and actively opposed repeal of the anti-substitution laws, believing that this would only lead to a deterioration in the quality of medicine available on prescription in Illinois.

6) Deliberated during formation of the Illinois Foundation for Medical Care and urges all members of this Society to help the Foundation succeed.

As directed by the 1971 House of Delegates, your Board of Trustees has collectively and individually opposed the special interests in Mt. Vernon, Ill. who propose to construct a 500-bed regional hospital for a region which already has a surplus of hospital beds. At the time of writing this report, the approval of a permit to construct this hospital has been granted after threatened litigation.

The state of the Health Manpower Bill in Washington is unknown. It is my personal opinion that this will be vetoed by President Nixon on the basis of economy. If so, I would urge your help in resurrecting that portion which provides funds for medical schools to establish departments of family practice and for hospitals to establish family practice residencies. This is the old Yarbrough-Rooney Bill which was pocket-vetoed last December, but passed each House of Congress by a sufficient majority that it probably could override a presidential veto. It would cost less than a tenth as much as the proposed Health Manpower Bill.

C. J. Jannings, III

SECOND VICE PRESIDENT

Your vice president has participated in many activities and meetings of the Society. In particular, two items are singled out which I believe are of interest.

The ISMS-CMS Joint Committee began early with plans for the development of an outstanding scientific program to be held at the Conrad Hilton Hotel, March 7-11, 1972. Under the able leadership of Dr. T. Howard Clarke, program chairman, an excellent diversified program consisting of postgraduate and instructional courses, panel discussions, symposia, lectures, scientific motion pictures and exhibits has been prepared. Eighteen specialty societies have responded affirmatively to an invitation to prepare an outstanding and appealing Clinical Conference. With an excellent faculty and topics of great interest, a large attendance is anticipated.

Illinois Regional Medical Program Committee on Regional Library Services

This is a relatively new committee which was appointed to 1) promote the establishment of at least a minimum core hospital library collection in the smaller hospitals of the state which presently do not have such a collection; 2) upgrade the competency of untrained personnel who staff libraries in the smaller hospitals; 3) provide access to library services for all health practitioners in the state. It is the hope that these objectives might be accomplished through participation in a series of one-day workshops conducted throughout the state, three of which have been held. The committee membership includes representation of hospital and medical librarians, hospital administrators, practicing physicians including a representative of the state medical society, and other health occupations. Once these objectives are obtained, the program may be united with that of the Midwest Health Science Library Service (5-state area) in providing resource material as needed by physicians in any community in the state.

William E. Adams

SECRETARY-TREASURER

The report of the Secretary-Treasurer will be found under Finances and Budgets, page 168.

TRUSTEES

First District

At the time of the Annual Meeting in May, and again this fall with the President's visit, the District meetings of the delegates were well attended. The enthusiasm and knowledgeability of the delegates has been especially gratifying and a source of pride for the contribution this district makes to the deliberations of the House of Delegates.

As the Illinois Foundation for Medical Care became formally organized, the Hospital Admission and Surveillance Program (HASP) was developed as its first activity. As a member of the IFMC Executive Committee, your trustee has been deeply involved in this project. This has in turn led to explanations and discussions of the program at several county medical societies throughout the district.

The year 1972 promises to be a momentous one for medicine. The need for a strongly organized medical society has never been greater. The bed rock of ISMS lies in the county societies and the support they give in meeting the coming changes in the health care delivery system.

Joseph L. Bordenave

Second District

My first year as trustee has been one concerned primarily with orientation. My plans for next year include attempting to stimulate interest in organized medicine in the second district, and to increase activity in both ISMS and the Foundation for Medical Care.

Allan L. Goslin

Third District

The Third District Trustees actively participated in branch society meetings as well as the Chicago Medical Society Council meetings, making quarterly reports of actions taken by the ISMS Board of Trustees.

The Council of the Chicago Medical Society, during the year, authorized the formation of the Chicago Foundation for Medical Care and created the Chicago Medical Society Insurance Trust to administer the various membership insurance programs available through CMS.

During the year the Third District added 242 new regular members and 127 resident members. Resignations, transfers and deaths totaled 270.

David S. Fox
Robert T. Fox
Eugene T. Hoban
Fredric D. Lake

William M. Lees
George Shropshire
Philip G. Thomsen
Frederick E. Weiss

Warren W. Young

Fourth District

During this year as Trustee for the Fourth District it has been my pleasurable duty to serve on several Board and ad hoc committees, and to act as consultant to councils and committees of ISMS. Participation in these deliberations is a valuable vehicle for input from the membership of the Fourth District, and except for a few insoluble conflicts, all meetings were attended.

It is difficult, at best, to project all of the feelings and opinions of the membership of this district, and equally difficult to report back to the membership the philosophy and actions of these committees, councils and the Board of Trustees. In an attempt to increase the very important county-state-county communications, District Meetings in different counties within the district have been held. One of the most recent was held in Macomb in early December. The matters discussed at this District Meeting were representative of the concerns of the membership, and the County and State Societies, such as the regionalization of health care services in this state. Foundations for Medical Care, and HASP. Certainly all in attendance gained from these discussions. Another District Meeting was to be held in January, in Peoria, and it is projected that at least three District meetings will be held in the year ahead. Although specific invitations are extended to county officers and delegates, all members are welcome and urged to attend.

In another area of activity, it was my privilege, serving as mediator and counselor, to aid in resolving a dispute between the staff and board of a very fine community hospital in this district.

In conclusion, it is my belief that the knowledge of activities of ISMS gained in my first year on the Board of Trustees has enabled me to be more effective in this second year of my term as Trustee for the Fourth District. It is my hope that the good communication channels with the membership and the county societies that have been developed will be utilized and increased so that I can better serve the district in the year ahead.

Fred Z. White

Fifth District

As in other districts of the state, the attention of the individual physicians of the county societies was directed in large part to the understanding of the medical foundation. Two meetings were held on this subject in the 5th district. It was evident that considerable education of the individual members was necessary to permit them to understand the implications of the foundation and also the fact that the foundation as such was not a regulatory apparatus.

After the acceptance of the HASP Program by the state IFMC Board of Directors, another educational effort was necessary. It was still evident in the meeting at Springfield that this particular program was not well understood. Again, it should be emphasized that this is a voluntary program and that it can be made to work only with the cooperation of individual physicians. It in no way supersedes any local foundation activity. This was misinterpreted and has caused some ill feeling. In this particular respect it should be emphasized that the old game of "considering the alternative" should be played to the hilt. A state regulated mechanism through unqualified inspectors would be abhorrent to all of us.

In the region of the McLean County Medical Society the danger of utilization of contract physicians was evident. With the present dearth of generalists and pediatricians, those who can not find ready counsel are encouraged to seek out-patient care at hospitals providing contract service. The physicians so employed are not screened carefully and in some cases have proved to be incompetent or worse. Furthermore, there was no control by the hospital medical staff of their activities. There has been some change in this respect in a local hospital in

McLean County so that Illinois Medical Society guidelines are being followed on paper. However, it must be emphasized that simply because a doctor is on duty 24 hours does not mean that he is qualified to perform true emergency care in the cases presented. This is particularly so when a trauma center is involved. Such a center is not helpful and may actually be destructive unless there is effective backup by skilled specialists.

We of the 5th district, which is Dr. Fruin's, wish him the best of luck in his present struggle to regain health. We miss him a great deal, as he has always been very close to us.

A. E. Livingston

Sixth District

A meeting of the Sixth District delegates was held October 5, 1971, in Alton, in conjunction with the President's Tour. It was well attended; discussion was largely about the proposed HASP program for IDPA patients. On the same date President Fruin spoke to the large group which attended the dinner meeting following the district conference; he was very well received. A district meeting will be held in March, 1972, in Chicago, immediately before the Annual Meeting of the Illinois State Medical Society; all delegates from the Sixth District are urged to attend.

In the past year no problems have arisen in the Sixth District which required the attention of the various District Committees.

The Foundation for Medical Care concept has not been enthusiastically received in the Sixth District; there is largely an attitude of "wait and see." Perhaps implementation of the HASP program will bring into clearer focus the relative merits of the Foundation program. The shortage of practicing physicians in the Sixth District remains; hopefully the newer medical schools located outside the large metropolitan Chicago area will eventually provide some relief of this distressing situation.

I have attended all meetings of the Board of Trustees during the past year, as well as most of the meetings of the Committees on which I serve. The tempo and amount of work for the Trustees increased; the chore would be entirely too burdensome were it not for the excellent support of the ISMS staff in both the Chicago and Springfield offices. They are due the appreciation of all members of the Illinois State Medical Society for their dedicated work in our behalf.

Mather Pfeifferberger

Seventh District

Shortage of physicians has been alleviated to some extent. Christian County has acquired five new members, Effingham County one, Marion County two and Bond County one. Clay, Christian, Fayette, Piatt and Shelby Counties are all in need of additional practitioners.

District Committees on Ethical Relations, Grievance and Prepayment Plans have had no call for meetings.

The majority of the members of the Societies in the Seventh District have individually signed a membership application to the Illinois Foundation for Medical Care. The Macon County Medical Society Committee on Foundation for Medical Care recommended rejection, at present, of I.F.M.C. membership until further study has been made. The recommendation was supported unanimously by the Macon County Medical Society.

Medicare benefit restrictions have been causing complaints in all of the component societies. This has resulted in a number of cancellations of hospital Medicare benefits by recipients. All disappointed recipients are being advised to complain to their Congressman.

Only one, Clay County, has reported the organization of a Health Maintenance Organization.

Continued Medical Education continues to be a first in Macon County. Sessions are titled "First Friday Conference." Credit approval for this course has been given by the American Academy of Family Physicians.

Hospital emergency service throughout the district has been functioning efficiently.

Hospital Admission and Surveillance Program is still in a state of flux awaiting court decision.

The Woman's Auxiliary continues to give devoted service and activities in support of the Medical Society Programs and A.M.A.—E.R.F.

Your Trustee again expresses appreciation to the component Societies and Auxiliaries for their work and cooperation.

Arthur F. Goodyear

Eighth District

During the past year I have visited all constituent societies in the eighth district, with the exception of the Lawrence and Douglas Societies. I have attended all meetings of the Board of Trustees and as many committee meetings as possible.

Eugene P. Johnson

Ninth District

I have attended all of the Board of Trustees Meetings and Committee Meetings during the past year.

There have been no district meetings of the delegates since May, 1971, at the Annual Convention. The district Grievance Committee functioned on one case because the county involved would not call a meeting of their county grievance committee. The grievance was settled satisfactorily to both parties. Neither the Ethical Relations nor Peer Review Committees have functioned, but the Peer Review Committee is expected to function when the Foundation for Medical Care gets under way.

Much interest still centers around the proposed 500 bed hospital to be located in Mt. Vernon. I've attended two meetings in Springfield before the Advisory Committee of the Department of Public Health. The Illinois State Medical Society in May, 1971, went on record as opposing this proposal—believing this construction would not be in the best interest of medical care for the area.

Several MECO students were in various hospitals in the district during the past summer and the physicians and students all benefited.

The various societies in the district have not shown as much interest in State Society affairs as in the past. It is hoped that the apathy will lessen in the future.

The ISMS staff are congratulated for another year of excellent work and dedication to the Society, and for their assistance when called upon.

Charles K. Wells

Tenth District

Activities and meetings attended:

1. Visits to county medical societies.
2. AMA—Clinical and Annual.
3. Regional Medical Program (Bi-State).
4. Comprehensive Health Program (ARCH) (Bi-State).

5. Belleville Area College—Department of Nursing.
6. Leadership Conference—Chicago 1971.
7. AMA Committee on Health Care of the Poor.
 - a) On site visit to Hugh Norwood Health Center, Cleveland, Ohio
 - b) Cooperation by AMA delegates in preparation of resolutions to AMA House of Delegates for state and county societies appointments on Health Care of the Poor.
8. All meetings of ISMS Board of Trustees.
9. 9th and 10th Districts meeting with Dr. Wells in conjunction with Southern Illinois Medical Society meeting in Belleville, November, 1971.
10. Illinois Comprehensive Health Planning liaison.
11. Nurse Scholarship Association of St. Clair County.

Developments:

1. Hospital expansion completed by some and begun by others.
2. Need for extended care facilities and nursing homes still unmet.
3. Maldistribution of physicians in southern counties unimproved.
4. Pilot HMO facility functioning under Carbondale Clinic personnel, Jackson County.
5. More evidence of ARCH (Bi-State CHP) concerned with planning and innovations for area involved.
6. Definite manifestation of Bi-State RMP interest and effort in delivery of health care.

Questions and concerns of physician members:

1. How will the IFMC relate delivery of health care to patients now and in the foreseeable future?
2. What assurance that their voice and input will be properly recognized by State IFMC.
3. Persistent distress over medical liability and protection for same.
4. Resentment over unfair representation to the public by some news media.
5. Displeasure with policies and practices of too many third party carriers.
6. Resolute that Southern Illinois University medical school must be supported in all ways.

Physicians and wives have exerted leadership and participation in health careers, nurse education, hospital expansion, and county health programs. Their efforts in special education and AMA-ERF have been significant.

Acknowledgment: Appreciation to the doctors and their wives for warm hospitality extended to the Scrivners on many occasions during the past nine years. Appreciation for services by ISMS staff and county executives. Gratitude for the opportunity to serve *all* the doctors and enjoy their camaraderie.

W. C. Scrivner

Eleventh District

In the past year your trustee attended all the quarterly meetings of the Board of Trustees and the annual and midwinter meetings of the AMA in Atlantic City and New Orleans, respectively.

Further, I was assigned two committees of the Board, *viz.* the Committee on Health Care Financing and as a consultant to the Peer Review Committee of the State. These committees were quite active and their individual reports should be reviewed elsewhere in this annual report.

A District meeting of the delegates was called; however, undoubtedly due to higher priorities the attendance

was again rather meager. The President's informative speech was well received by those in attendance.

Because of the dramatic changes that are proposed in the health care delivery system, it is of extreme importance that each and every practitioner of medicine keep fully informed as to his role in these changes. He should actively participate in informing his representatives on local, state and national levels as to his understanding of the problems and his feelings towards these changes.

Joseph R. O'Donnell

TRUSTEE-AT-LARGE

The lessened responsibilities of the Immediate Past President serving as Trustee-at-Large is a marked contrast to the rigorous demands during the presidential year.

With the exception of the July meeting, I have attended all the meetings of the Board and have served as a board member on the Illinois Foundation for Medical Care. I represented the State Society at a meeting at the Annual Dinner of the Illinois Nursing Home Association held in Springfield, September 20.

Extending my emphasis on Continuing Education, outlined as one of my four main areas of special emphasis during my presidency, I have as advisor worked with the staff and Dr. Cannady in trying to get the Independent Council on Continuing Education activated. It is my hope and expectation to continue to help to make the Council a functioning reality.

It has been particularly gratifying during this past year to assist in setting up the Illinois Foundation for Medical Care. In my opinion, this will be the mechanism through which physicians will be integrated into the changing patterns of medical care delivery and be permitted to keep control of patient care, which I believe is essential if patients are going to receive competent attention.

In retiring from the Board of Trustees, I will end twelve years of service, nine of which were as a Trustee, one as president-elect, one as president, and now one year as Trustee-at-Large. I highly appreciate the honor in serving in these capacities and am grateful for the opportunity of working on many different committees.

One cannot find a more dedicated group of men than the officers, trustees and committeemen with which I have been privileged to work. I would also express my great appreciation to our most efficient staff who work with a dedication seldom seen. To them, I wish to express my profound thanks for their assistance during my years on the Board.

J. Ernest Breed

CHAIRMAN OF THE BOARD OF TRUSTEES

Your chairman, in attempting to fulfill the requirements and responsibilities expressed and expected of the office, has endeavored to promote unity, strength and efficiency in conducting the affairs of the Board of Trustees.

1. All appointments to committees or councils and ad hoc task forces were made upon trustees' recommendations.
2. Special appointments and envoys to represent ISMS at various meetings and affairs were chosen because of their ability and availability to do the best job for ISMS.

3. The Board has implemented policy and instructions received from the House of Delegates while exercising alertness for new trends and developments having a bearing on freedom and responsibilities of ISMS members.

Developments:

1. Fulfilled mandate to bring into being the IFMC.
2. Fostered closer liaison with county society officers and executives.
3. Enhancement of Board with additional authorized members from District 3.
4. Fruition of first annual meeting of ISMS and CMS in March, 1972.
5. Execution of a mutually satisfactory employment contract with Mr. Roger White.
6. Convened a successful and pleasant October Board meeting in Rockford.
7. Through cooperative legislative effort, will have caused development of Department of Family Practice in all state medical schools.
8. Implemented House of Delegates action to foster medical careers and assist financially minority groups to extent of \$13,000 through efforts of task force on physician shortage and deprived areas.
9. Sponsored a Job Fair attended by representatives of 72 communities and visitors to enlist some 250 newly licensed physicians to come to their areas to practice. An event of public service and significant public relations acclaimed by all.
10. A successful leadership conference in November with admirable performance by representatives from ISMS and AMA before large audience with news media coverage.
11. Sustained cooperative effort with state and federal legislators to bring into focus the whole problem of sickle cell anemia.
12. Providing medical liability coverage through state policy to some 3,000 practicing physicians.
13. Conducted an official hearing for representatives of a Spanish colony of welfare recipients on their problems and our appropriate constructive response.
14. Provided physician families and friends outstanding popular travel seminar at a substantial saving.
15. The task of acquiring a successor for Mr. Tim Selleck who met an untimely death while on active duty.
16. At request of Dr. Fruin, President, presented ISMS check for \$180,000 to AMA-ERF chairman, Dr. John Chenault, in New Orleans with accompanying remarks on ISMS leadership in its state and nationally due to Illinois contribution of \$3,000,000 to AMA-ERF fund since its inception. The House of Delegates of the AMA responded warmly.
17. Fostered fiscal consciousness in all activities and disbursements of the Society.
18. Personally reviewed performance records of staff furnished by Mr. Roger White.
19. Attempted to respond satisfactorily to all complaints and requests of members of the Society.

Recommendations for present and long range goals:

1. Press for constructive, favorable developments in medical liability.
2. Encourage involvement by members in structured activity of the Society and areas affecting delivery

of health care and continuing education.

3. Strive to secure desirable sponsorship of "Pulse" publication.
4. Endeavor to successfully refute the claim by IRS of some \$30,000 for their interpretation of tax liability from *Journal* income.
5. Require the IFMC to consider the Peer Review Committee of ISMS as the supreme appellate body for all members of ISMS seeking redress for a ruling of state HASP matters of the Foundation.
6. Foster informative programs for members to acquaint them with services available through the ISMS.
7. Continue assistance to Woman's Auxiliary to ISMS whenever and wherever possible.
8. Dedicated cooperative effort with the AMA delegation to select and prepare prospective members to serve at all levels of AMA activities.
9. Ask the AMA to provide a Society survey of our total operations, as Dr. Jirka and Mr. White will do for the Texas Medical Society, January 20 through January 23, 1972.
10. Depending upon the occasion and matter under consideration, utilize boldness, tact, and diplomacy in conveying to all government agencies, third party carriers and others, a clear understanding of what the practicing physicians of Illinois stand for and what they will not stand for.

Acknowledgments: The achievements and transactions of the Board of Trustees have been made possible through the cooperation and performance of the members of the Board, committee chairmen, and our staff.

W. C. Scrivner

SPEAKER OF THE HOUSE

The House of Delegates meeting at Arlington Park Towers was a challenging and rewarding experience, and this year's assembly at the Conrad Hilton promises to be more exciting.

Combining our Annual Meeting with the Clinical Session of the Chicago Medical Society provides us with the opportunity and potential of contributing to one of the outstanding medical meetings in the Americas. In a contemporary relevant sense, we can fulfill the purpose of ISMS as defined in Article II of our Constitution.

What of the business in the past year? Your officers have labored long and hard on your behalf and I hope you will read all of the reports that are published in this *Delegates Handbook*. Then you will have prepared yourself for the forthcoming meeting.

1972! What does it bring? What you, the delegates, put in and bring out as policy for your Society and officers to follow in the next year. To that end, I repeat, from last year:

Register early and review additions to the Handbook. Be on time for the sessions (they will begin on time). Attend your District Meetings. Testify at the Reference Committee hearings. If in any Committee meeting on Tuesday night you are not adequately heard, call for me or Dr. Brislen at Headquarters, and we will assist you. Know your facts; debate the issues; sell the Reference Committees. On the floor of the House, help expedite the business.

Many and important issues confront us. Let us be mindful of their significance and act with vigor, foresight and concern.

Paul W. Sunderland

VICE SPEAKER OF THE HOUSE

There is no report at this time.
Andrew J. Brislen

EXECUTIVE ADMINISTRATOR

Implementation of 1971 House of Delegates Actions

All resolutions adopted by the 1971 House of Delegates have received attention as directed. All referred resolutions have been assigned to an appropriate Council or Committee for study. Further discussion on the latter may be anticipated in the current reports to the House of Delegates.

The Society's Leadership Role

Throughout the year a huge volume of information on most contemporary medical issues constantly flows through the Society's eight Councils and 40 Committees. Frequently (this year in particular) additional Ad Hoc Committees are convened to deal with special issues. After a sifting and sorting process with the Councils and Committees, significant points came before the Board of Trustees for disposition, in line with the broad policies established and modified by the House of Delegates, meeting at the annual session. This is the process by which the Society establishes and maintains its leadership role on behalf of the membership. As an offshoot of the process, the Society speaks to the issues through the news media (usually by the President), is called upon constantly to give advice and counsel to important legislative bodies and regulatory agencies and to recommend physicians for appointment to most such agencies or advisory committees. For a presumed variety of reasons, many members could easily overlook this as a membership benefit, yet it is of the utmost importance. To fully appreciate its importance, one must visualize where the profession of medicine would stand today without it. I call it to your attention for two reasons. First, it constitutes the life blood of any professional association. The quality of the leadership role is a direct measure of the success of any organization. I take satisfaction in believing that the Society currently enjoys a respected place in medical affairs in the state of Illinois. At the same time I humbly concede that room for improvement always exists. Second, the leadership function constitutes the bulk of the Society's activity. To maintain the leadership role under today's conditions requires an ever increasing effort on the part of the officers, councils, committees and staff.

Staff Complement

The staffing pattern remains as reported to you in May, 1971—32 full-time employees, 5 part-time or contract employees, plus the *Journal* Editor and Legal Counsel who serve on part-time retainer (an increase of 1 full-time employee since 1964). No increase in staff is contemplated. We shall continue, as in the past, to develop priorities of staff time to accomplish those things which are of greatest importance. We were saddened during the year by the death of two employees, Frances Zimmer shortly after her retirement and Timothy Selleck, Director, Governmental Affairs Division, who was killed in an airplane crash enroute to Springfield on Society business. I wish to pay tribute to a staff which I commend to you as both competent and dedicated.

Finances

Under the aegis of the Secretary-Treasurer, Finance Committee and the Board of Trustees, hopefully the expenditures of the Society have been handled in a fashion which you regard as prudent. As reported to you elsewhere, available funds to meet the ever increasing toll of inflation and the need for a greater tempo of activity are no longer available. The dues increase granted in 1965 has been carefully conserved to cover increased cost of operations for the six-year period. Proposals to meet this contingency during 1973 and beyond will be forthcoming.

Illinois Foundation for Medical Care

As directed by the House of Delegates, the Illinois Foundation for Medical Care was incorporated in June. In October the Foundation negotiated its first contract to operate a Hospital Admission and Surveillance Program (HASP). Your Executive Administrator has been appointed and serves the dual role of Executive Vice President of the IFMC. Much time and effort has gone into the development of HASP. A current and full report of IFMC activity will be presented at the Annual Meeting.

Appreciation

The staff is in contact with the Chairman of the Board and the President almost daily, seeking direction and guidance in the affairs of the Society. The burdens placed upon those men by staff alone is enormous. We wish to express our deepest gratitude to Dr. Willard Scrivner and Dr. L. T. Fruin. Similarly, we thank all of the officers, members of the Board of Trustees, Council and Committee chairman and members and the Auxiliary officers for their assistance to the staff. Their example of selfless dedication to the Society's work has been an inspiration to us.

Roger N. White
Executive Administrator

DELEGATION TO THE AMA

The Illinois Delegation to the American Medical Association met twice during the year—in May during the ISMS annual meeting and again in October during the Board of Trustees meeting in Rockford—as well as meeting daily during the AMA annual meeting in Atlantic City and the clinical meeting in New Orleans.

At each of the AMA meetings, the delegation met prior to the opening of the House of Delegates to study and discuss published reports and resolutions. Members of the delegation were assigned to attend reference committees and report back to the full delegation at breakfast meetings which were held daily.

In Atlantic City Dr. Joseph Mallory served as a member of Reference Committee C (Medical Education) and Dr. Edward Cannady on Reference Committee H (Miscellaneous). Dr. Jack Gibbs, an alternate delegate, was seated in the House for Dr. Harlan English, who was unable to attend.

The Illinois delegation introduced nine resolutions at the annual meeting. Following is the action taken on each:

No. 30 EXPANSION OF MECO PROJECT

RESOLVED, That the American Medical Association House of Delegates requests the Board of Directors of the AMA Education and Research Foundation to investigate the feasibility of providing financial aid for the

continuation and coordination of the Student American Medical Association Project for Medical Education and Community Orientation (MECO). **ADOPTED.**

No. 31 AMA-ERF FUNDS FOR NEW MEDICAL SCHOOLS

RESOLVED, That the American Medical Association urge the AMA Education and Research Foundation to add all new medical schools to its list of colleges eligible to receive this support. **ADOPTED.**

No. 32 AMA DRUG EVALUATION

RESOLVED, That future editions of the *AMA Drug Evaluations* (AMA-DE) avoid the use of the word "irrational"; and be it further

RESOLVED, That this resolution be referred to the AMA Council on Drugs and the Committee responsible for the 1971 *AMA Drug Evaluations* publication. **ADOPTED AS AMENDED.**

No. 33 OUTPATIENT SURGERY

RESOLVED, That the American Medical Association endorse the concept of outpatient surgery under general and local anesthesia for selected procedures in selected patients as good medical practice. **ADOPTED.**

No. 34 NEED FOR CONTROL OF THE IMBALANCE AMONG DIFFERENT MEDICAL SPECIALTIES.

RESOLVED, That (1) the subject of the number of residents, their distribution among the residency programs in the various specialties and the relation of the number of residents in training in the various specialties to the supply of a need for physicians in the various specialties be referred to the Council on Medical Education for its continuing study, (2) information concerning these matters be supplied through appropriate channels to medical students, interns, residents, medical schools and hospitals involved in graduate medical education, and (3) regular reports on these matters be made to the House of Delegates. **SUBSTITUTE RESOLUTION ADOPTED.**

No. 35 DOCTOR DRAFT

RESOLVED, That the House of Delegates of the American Medical Association considers the physician draft to be discriminatory and detrimental to efforts to increase the supply and utilization of health personnel in areas of critical shortage in the United States; and be it further *RESOLVED*, That the physician's draft be considered an integral part of any and all draft proposals; and be it further

RESOLVED, That this resolution be sent to all appropriate persons and agencies concerned with the physician's draft. **FILED.**

No. 36 EMERGENCY HEALTH PERSONNEL ACT OF 1970

RESOLVED, That the House of Delegates of the American Medical Association officially endorse the Emergency Health Personnel Act of 1970 as currently enacted; and be it further

RESOLVED, That the American Medical Association solicit support and cooperation from state and county medical societies and local physicians for the implementation of this act; and be it further

RESOLVED, That this resolution be sent to all individuals and agencies concerned with the implementation of this act. **REFERRED TO BOARD OF TRUSTEES AND APPROPRIATE AMA COUNCILS AND COMMITTEES.**

No. 37 COMMUNITY HEALTH WEEK

RESOLVED, That Community Health Week be held in winter or spring each year rather than in October. **FILED.**

No. 61 IMPLEMENTATION OF WORK PROGRAM RECOMMENDED BY THE COMMITTEE ON HEALTH CARE OF THE POOR

RESOLVED, That, to initiate programs applicable to its area, state and local medical societies be urged to appoint a committee on Health Care of the Poor, or assign this function to an appropriate existing committee, and that these committees maintain liaison with the AMA Committee on Health Care of the Poor. **SUBSTITUTE RESOLUTION ADOPTED.**

At this meeting the Illinois delegation was host to approximately 500 delegates and alternates at a luncheon, and it held open house in its suite for three evenings.

At the clinical session in New Orleans, Dr. Maurice M. Hoeltgen served as a member of the Committee on Credentials, Dr. Francis Young as a member of Reference Committee C (Medical Education) and Dr. Theodore Grevas as a member of Reference Committee F (Officers and Trustees). Drs. Joseph O'Donnell and Morgan Meyer were seated in the House for Drs. Harlan English and Edward Cannady, who were unable to be present. Dr. Theodore Van Dellen, an alternate, was seated for Dr. Philip G. Thomsen, who could not attend and Dr. Charles K. Wells, an alternate, was seated during the final session of the House, on Wednesday, December 1, for Dr. Grevas, who was not present.

At this session, two resolutions which originated in Illinois were introduced by individual members of the delegation. Dr. Hoeltgen introduced **No. 32 NATIONAL LICENSURE OF PHYSICIANS**, which was adopted as follows:

RESOLVED, That the American Medical Association oppose the concept of national licensure of physicians; and be it further

RESOLVED, That the American Medical Association support the preservation of State Boards of Examiners; and be it further

RESOLVED, That the Federation of State Medical Boards of the United States review current methods of licensing, with particular attention to inter-state reciprocity, to discover, anticipate and correct deficiencies relative to national physician distribution.

Dr. Edward A. Piszczek introduced **No. 33 SICKLE CELL ANEMIA**, for which a substitute resolution was adopted as follows:

RESOLVED, That research efforts directed to the prevention of sickle cell crises and development of treatment forms to reverse the sickling process be encouraged; and be it further

RESOLVED, That the American Medical Association encourage efforts to evaluate the effectiveness of screening and counseling programs for sickle cell trait and sickle cell anemia; and be it further

RESOLVED, That the American Medical Association support ongoing research programs to identify the characteristics of sickle cell disease and develop treatment programs.

At the opening session of the House of Delegates in New Orleans, Dr. Willard C. Scrivner, Chairman of the ISMS Board of Trustees, presented to the AMA Research and Education Foundation a check for \$180,000. It was announced that this check brought to \$3,146,360 the total

amount contributed by Illinois doctors to AMA-ERF. Also at this session, Dr. Milton Halperin, Chief Medical Examiner of New York City, was voted the AMA Distinguished Service Award which will be presented at the June meeting, and Mac F. Cahal J.D., former Executive Director and General Counsel of the American Academy of General Practice, received a Citation of a Layman for Distinguished Service.

The delegation has observed that certain individual delegates from other states have managed to acquire expertise useful to the AMA and, as a result have been appointed to AMA Committees and Councils. Illinois' own Dr. Joseph Skom, long-time chairman of the ISMS Narcotics Committee, was recently appointed to the AMA Committee on Alcoholism and Drug Dependence for this reason. It is recommended that members of the Illinois delegation to the AMA, particularly, be encouraged to become active in state society committees in order to have a better chance for elective or appointive positions at the AMA. A number of delegates and alternates are trustees of ISMS and they, as well as the delegation's chairman and/or secretary, attend regular meetings of the Board. However, there is still a need for other members of the delegation to become active at the state level by participating in committee work.

H. Close Hesselstine, *Chairman*
Carl E. Clark, *Secretary*

PRESIDENT OF THE WOMAN'S AUXILIARY

Outstanding accomplishments are written on the pages of the 1971-72 history of the Woman's Auxiliary to the Illinois State Medical Society. Each of our 3,200 members has participated in some phase of volunteer service to promote better health and good will in all of our Illinois communities. Their activities, talents, and interests, varied as the colors in a spectrum or flowers in a garden, have been apparent in their efforts and combined to make life a little happier for the people of Illinois.

Each county presents a unique health problem to be met, a need for healthful assistance, and demands all the time and effort a doctor's wife can afford. Our members have responded in diverse ways. For instance, three of our Chicago Auxiliaries conducted a language orientation course for foreign interns. Medical subjects were stressed in each lesson. The series helped to make the foreign doctors' stay in our country happier, more worthwhile and meaningful because the lessons also included assistance in how to shop in supermarkets, how to cook American foods and how to communicate in our language.

The "bridge" to good health was a project of several county auxiliaries. The proceeds for their bridge marathons went to scholarships for deserving students in the field of health careers, as Boone County, one of our

smallest auxiliaries, does annually. The Winnebago Auxiliaries concentrated on health careers and raised enough money through a fashion show to provide six nursing scholarships.

Will-Grundy County started a "time bank" which coordinates the services and hours volunteered by members of several community organizations and individuals. A volunteer enlists her available time and talents. When one is needed to deliver meals to the homebound, provide transportation to the doctor's office, run errands, visit the elderly in nursing homes or any other health care duty she is called by the "telephone volunteer" who has received the call for assistance from a commercial answering service.

To teach the dangers of drug abuse to teenagers has been the main goal of many county auxiliaries. Lecture programs with literature have been presented to schools as have motion picture portrayals. Lake County's drug film is in such demand that it is being cleared through the County Building Offices and must be reserved weeks in advance.

Warren County sponsored a health education program for the parents of sixth graders in Monmouth. The attendance at all "Three Evenings For Your Child" far surpassed the hopes of those who planned the projects. The programs featured specialists in specific areas and covered the topics of "Physical Growth Patterns and How They Relate to Behavior," "Learning and Its Effect on Behavior," and the "Emotional Relationship Between the Sixth Grader and His Parents."

All of our departments have been "Go" all through this year. We divided our activities into two oriented groups. Our Community Health Volunteer Services, spotlighted above, were under the direction of Vice President Mrs. Robert Hartman. The other dealt with programs and administration under the supervision of Mrs. Thomas Tourlentes. Our AMA-ERF chairman has added so much enthusiasm to her job of selling glamorous products that she is about the most active chairman this year. The proceeds will hopefully put Illinois in a winner's circle this year. The Benevolence Fund also should show a good increase this year due to a better understanding of its functions, explained by our chairman at the workshops.

These are only a few of the great services given by our Illinois doctors' wives. All of the reports are not yet compiled and many county projects have not reached fruition. Each of our state chairmen, officers, councilors, and county presidents have evinced great pride in being an Illinois Medical Auxilian and there has been true joy in accomplishment. Because they have faithfully and energetically fulfilled their duties this short year will be an outstanding one.

Mrs. David J. (Adele) Kweder

President's Dinner—March 9, 1972

Committees of the Board of Trustees

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Advisory Committee met with the Auxiliary October 9th to review Auxiliary activities and ISMS' financial support of the organization.

The committee is impressed with the progress made by the Auxiliary since February, 1971, when it employed the part-time services of Mrs. Jane Swanson as its Executive Secretary. Mrs. Swanson—who works out of the Auxiliary office in Monmouth—has done an excellent job of upgrading the organization records, reports and programming during the past year.

While its membership is only 3,001, the Auxiliary proves extremely effective in raising funds for the AMA-ERF and the ISMS Benevolence Fund. Last year, it contributed \$12,449 to AMA-ERF and \$7,136 to the Benevolence Fund, for which we are grateful.

In view of Auxiliary accomplishments last year, this committee recommended an increase in ISMS' financial support of the organization for 1972.

The only area of concern to us is its declining membership in the Chicago area. Of its 3,001 members, less than 500 are from Cook County. This is especially discouraging considering the fact that there are about 6,500 Cook County physicians holding membership in organized medicine.

The Advisory Committee is grateful to Auxiliary President Mrs. David Kweder, her officers and the entire Auxiliary, for their tireless efforts to support the Illinois State Medical Society in its activities.

Frank J. Jirka, Jr., *Chairman*

L. T. Fruin

Willard C. Scrivner

CONSTITUTION AND BYLAWS

All amendments to the Constitution and Bylaws that were ordered by the 1971 House of Delegates were made in the copy published in the October, 1971, Reference Issue of the *Illinois Medical Journal*.

At its meeting on October 9-10, 1971, the Committee on Constitution and Bylaws voted to re-write major portions of the Bylaws, which have become unwieldy and inflexible through amendments over the years, to eliminate duplication and clarify certain sections.

These proposed amendments, dealing principally with membership classifications and the Society's committee structure, will be presented to the House of Delegates in resolution form.

Charles K. Wells, *Chairman*

Frederic D. Lake, *Co-Chairman*

Arthur F. Goodyear

Warren W. Young

Frank M. Pfeifer

Consultants

Paul W. Sunderland

EDUCATIONAL AND SCIENTIFIC FOUNDATION

The Educational and Scientific Foundation of ISMS was established in 1961. The Foundation is incorporated in Illinois, and financial support is tax deductible. It is dedicated to the advancement of medical knowledge and the education of the public, particularly in the State of Illinois.

A Board of Directors, which consists of the ISMS president, the immediate past-president, the secretary-treasurer and the chairman of the Board of Trustees, manage the Foundation. During the past year the directors voted to add the ISMS president-elect to the Board.

The immediate Past-President serves as Chairman of the Foundation Board and the Secretary-Treasurer of the Society occupies the same post in the Foundation. There are three classes of membership in the Foundation.

1. Fellows of the Foundation are physicians holding regular membership in the Foundation following the contribution of \$100 or more.
2. Associate fellows are non-physicians holding regular memberships in the Foundation following a contribution of \$100 or more.
3. Honorary fellows are individuals whom the Foundation's Board of Directors elect to membership because of their exceptional service to the organization and its goals.

During the year, the Foundation took the following actions:

- A. Established its own bank account for receipt and disbursement of funds.
- B. Appropriated \$5,000 from unrestricted funds to pay the University of Illinois for setting up a medical self-testing unit at the 1971 ISMS annual convention.
- C. Allocated \$1,550 from unrestricted foundation funds for the purpose of operating the 1971 SAMA-MECO project.
- D. Voted to release foundation funds allocated to unmet health care needs for paying consultants to advise ISMS on establishing a health care foundation in Illinois.
- E. Voted to finance from unrestricted funds the production costs of a brochure on Hospitalization of the Mentally Ill to be prepared by the Council on Mental Health.
- F. Allocated \$2,500 from Publication Improvement funds to be used for a membership opinion survey.
- G. Approved a loan of \$30,000 to the Illinois Foundation for Medical Care.
- H. Contributed from unmet medical needs:
 1. \$10,000 to the Medical Opportunities Program
 2. \$2,000 to the Council for Bio-Medical Careers
 3. \$1,000 to ASPIRA.
- I. Voted to cover up to \$500 in expenses connected with the ISMS exhibit at the Illinois State Fair.
- J. Loaned \$20,000 to the Student Loan Fund to bolster the fund until individual loan repayments match outgo of loans.

The foundation continued to disburse funds received from Merck Sharp & Dohme for the operation of a Scientific Speakers Bureau. Although Merck's 1971 grant was smaller than it had been previously, it was possible to pay the expenses and honoraria to 27 physician speakers addressing medical societies in the following counties: Coles-Cumberland, De Kalb, Knox, LaSalle, Livingston, and Whiteside-Lee.

J. Ernest Breed, *Chairman*

Willard C. Scrivner
L. T. Fruin

Jacob E. Reisch
Frank J. Jirka, Jr.

HEALTH CARE FINANCING

During the past year the Committee played the dual role of serving as ISMS liaison to the Illinois Department of Public Aid, and as the Executive Committee of the Illinois Foundation for Medical Care. In the latter role, the Committee was very active, meeting almost monthly, to resolve many issues confronting the newly formed IFMC. These activities are to be reported in the foundation's annual report.

Creation of HASP

As the Committee on Health Care Financing, it heard the report of IDPA's proposed cuts in the welfare program. This information was reported to the Board of Trustees and led to the eventual creation of the Hospital Admission and Surveillance Program (HASP) by the Illinois FMC.

The Committee also discussed several problems with IDPA regarding the Department's payment policies. These problems involved complaints from physicians about reduction in fees and delays in processing claims.

Meeting With CHAMPUS

During the year, the Committee met with representatives from CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). CHAMPUS requested ISMS cooperation in providing the necessary peer review for its program. The Committee reported this information to the Board of Trustees.

Joseph R. O'Donnell, *Chairman*

Frank J. Jirka, Jr.
George Shropshire
Frederick E. Weiss

Eugene P. Johnson
Joseph L. Bordenave
Jacob E. Reisch, *Consultant*

OSTEOPATHIC PROBLEMS

Due to the fact that there have been no difficulties arising between these professions during the past year, there has been no reason for the Committee to meet.

No report.

Arthur F. Goodyear, *Chairman*

Eugene P. Johnson
Frederick E. Weiss
Fredric D. Lake

POLICY COMMITTEE

During the past year, the Policy Committee reviewed the actions of the 1971 House of Delegates, and added policy statements on the following subjects to the ISMS Policy Manual:

AMA-ERF contributions, birth control, blood procurement, comprehensive health planning, foundations for medical care, hospital medical staff-management relationships, medical examiners, nutrition, and substitution of the prescribed drugs. It also added to existing policy on legislation and developed a statement from previous House action on abortions.

The Board of Trustees, which approved all of the above, referred back to the policy committee a resolution on out-patient surgery, for further study.

The committee attempted to separate administrative from medical policies in the new manual, but found that this was not feasible because some policies could be considered both administrative and medical.

Joseph L. Bordenave, *Chairman*

William E. Adams
David S. Fox

PUBLICATIONS COMMITTEE

During the year 1971, the *Illinois Medical Journal* appeared regularly (on a monthly basis) with no internal or printer delays for any issue. The total number of pages printed was 1,276, an average of 106 per month.

The Publications Committee has determined that a minimum monthly average of 96 pages is essential to guarantee a well-balanced *Journal*. (Of course, the amount of advertising determines to a great extent the number of pages available.) The committee has also established content guidelines of 2-2-1, i.e., 40% advertising, 40% clinical medicine and 20% organizational items.

In analyzing and evaluating the year's operation, we find a 2% reduction in the number of pages printed. During the recent past, the total pages printed by year has been:

1965	1,408	1969	1,510
1966	1,574	1970	1,304
1967	1,768	1971	1,276
1968	1,608		

The variations in number of pages printed is a direct reflection of net advertising revenue. Adherence to the content guidelines as concerns advertising was well observed for 1971, there being 483.5 pages (37.8%). However, because of the many and varied items of organizational importance occurring during 1971, the ratio of this segment to clinical articles was not maintained. The clinical material carried represented articles in 15 specialties. The largest number was in surgery, but a good over-all balance was achieved to meet the varied interests and desires of the membership. In addition, self-testing features, such as Viewbox and EKG, were maintained. In retrospect, the clinical medicine section of the *IMJ*, occupying nearly 50% of the editorial pages, contributed to keeping *IMJ* a recognized, accepted source of continuing education.

Circulation

Circulation increased 17% during 1971. Distribution, in accordance with House of Delegates action, was extended to residents, interns and members of SAMA in Illinois. Initial data presented to the House of Delegates had indicated that circulation to these groups would total approximately 1500. However, when the actual mailing lists were received they included over 3,350 names. After four months' experience, it was evident that the budget (additional \$2 per member dues assessment) was inadequate for this larger number. Therefore, beginning in May, circulation was made to members of SAMA (800), and one-third of the residents and interns (950) on a rotating basis. Starting in January, 1972, copies will go regularly to all, since the 1971 House of Delegates provided for this expenditure by increasing the assessment for 1972. Additional copies of the *IMJ* are circulated as follows: domestic—162; foreign—40; exchange and complimentary to medical societies, pharmaceutical industry, qualified individuals in paramedical professions—575; accredited hospitals—316.

Advertising

Advertising carried during 1971 included 71 pages of four-color, 85½ pages of two-color, 219 pages of black and white, 13 pages of classified and 91 inserts. This generated a net revenue in excess of \$118,000. Initial planning for 1971 a year ago had indicated anticipated revenue 8% higher. In actuality, 1971 revenue was 5.6%

below 1970. While other factors are involved, the decrease is largely due to the decreased number of four-color ad pages printed in 1971.

We all know that 1971 was similar to a roller coaster track financially. The stock market hit highs and lows in quick succession. This led to uncertainty and hesitancy on the part of the advertisers. Another factor producing the same cautions were the FDA activities. The lack of approval of new pharmaceutical products meant fewer advertising pages. In addition, FDA regulation of advertising copy, full disclosure and the threat of developing statements of efficacy further decreased advertising copy. Since all of these factors are outside the control of the Publications Committee and the staff, and since advertising pages are the lifeblood of the *IMJ*, the committee instructed staff to evaluate additional advertisers, including those in non-pharmaceutical ventures.

Advertising rates were reviewed in 1971. A study of our basic expenses, plus increased postal rates, higher labor costs and mark-ups on paper, indicated the need for an increase. Therefore, in July, an increase amounting to approximately 11% was approved for 1972. However, the economic stabilization controls came along, negating some of the proposed changes. It is possible that some increases may be made effective in the second half of 1972. We have again set our anticipated net advertising goal for 1972 at \$120,000, but admit that at this time it is a "floating figure."

Readership Survey

Renewed confidence in the *Illinois Medical Journal* as a primary communication medium and a dispenser of continuing medical education is among the results of an independent readership survey conducted by Professional Research Analysts. PRA conducted the survey in four parts during 1971. These were (1) an average page exposure check-check, (2) interviews with the membership, (3) reader interest cards and (4) a review of procedures. Principal results of this survey showed:

1. A readership of 38% (and 40% if there is inclusion of others who found the check study for the physicians);
2. A variance of readership of less than 1/2 of 1% in all areas of the book;
3. Specialists utilize the *IMJ* to as great a degree as generalists.

A new advertising sales brochure is being developed based on the conclusions of this survey, and a general mailing of the brochure to pharmaceutical firms and advertising agencies will be made.

Internal Revenue Service Audit

For over 70 years the *Illinois Medical Journal* has been published as a means of communicating continuing medical education to the membership and informing the members of activities of organized medicine. Beginning in 1904, commercial advertising was accepted, such advertising being that of pharmaceutical companies and the items advertised were those that would benefit the physician and his practice or be of use to his patients.

In 1969, the U.S. Congress passed the Revenue Reform Act of that year. Under this Act, regulations which had been applied by the Internal Revenue Service for three to five years previously were codified. One of these regulations had to do with taxing exempt organizations on the activities generating revenue, if those activities were

not related to the exempt function of the organization. It was decided (by IRS) that the advertising portion of the *IMJ* was not related to the exempt function of ISMS and that is was only a method being employed to generate income. In our opinion and in reality, the items advertised **are** related since they do give information of use in the physician's practice. However, the IRS sees this differently.

As a further extension of this, the IRS is trying to prove that the *IMJ* is comparable to profit-making publications, and that as a result we should be allocating more of our dues dollar to cover the cost of publication.

Legal counsel and our auditors have this matter under intensive study. This is due to the fact that in early August, ISMS was notified that a back tax was due on *IMJ* income for 1968 and 1969. The amount claimed by IRS was in excess of \$30,500.

As of the time of the writing of this report, an appeal has been filed for a conference hearing. IRS has indicated it will be doing a re-audit of the years 1968-1969. The outcome may not be known for several months. In the meantime, the Publications Committee has been considering alternatives which may be available to eliminate the tax liability of ISMS in this respect.

"Pulse"

"Pulse" continued in publication during 1971. It is a well received periodical which reflects news of the Society, items to keep the membership abreast of changes in the mode of medical practice in Illinois, and gives publicity and notice of events affecting individuals and local groups within the Illinois medical community. The Publications Committee continued to review "Pulse" to ensure that it was fulfilling its role as a medium of communication. The *IMJ* Readership Survey also included questions concerning "Pulse" in the personal interview section. The results of the survey indicated that the readership of "Pulse" was in the neighborhood of 75% of the membership.

Early this fall, ISMS was notified by Roche Laboratories that they could no longer continue the sponsorship of "Pulse." Roche had been the sponsor for six years and they felt they had achieved their purpose in publicizing their products through this brochure. As a result, the Publications Committee immediately requested staff and our media representative to seek a new sponsor. Contacts have been made with nine major pharmaceutical companies, and while most have been interested, each has been unable to write it into their advertising program. As of this writing, one company has evinced great interest and may assume sponsorship in February or March of 1972. However, no contract has as yet been signed.

The Publications Committee's present plans are to continue publication of "Pulse" for at least four months in a 4-page format starting in January, 1972.

Additional Responsibilities

Since it will not be noted in other reports to the House of Delegates, mention should be made of the many other responsibilities of the Division of Publications. During the past few years an ever-increasing percentage of the Society's various newsletters, pamphlets, brochures and booklets have been printed in the Society's print shop. In 1971 this has reached the point where at least 90% of all forms of printing (excluding the *IMJ* and "Pulse") have been printed there, all with no increase in staff.

Acknowledgments

The Publications Committee takes this opportunity to officially acknowledge and make a matter of record the dedication of Mr. Richard Ott and his staff in the Division of Publications and Scientific Services. By developing time schedules and establishing a system of priorities, not only has production in this department been notably increased but also many additional projects have been accomplished "in house" rather than being printed "outside." This has saved the Society a considerable amount of money and has at the same time made mailings more prompt.

A similar acknowledgment and thank you is also extended to those responsible for so efficiently managing the Society's print shop and mailing department. The abilities of these individuals have been "put on the spot" numerous times during the year and always they have achieved what seemed the impossible.

Jacob E. Reisch, *Chairman*

A. Edward Livingston

Warren W. Young

Robert T. Fox

Editorial Board

The Editorial Board met twice during the past year. At each of these meetings pending manuscripts were reviewed by inventory, and items on which the editor needed advice were covered. All members of the Editorial Board have been urged to submit editorials and papers and to solicit such items from their associates.

A substantial editorial was submitted by the chairman which debated the merits of proposed FDA policies on combination drugs. The editorial reflected the feeling of the Editorial Board and in addition, other members of the Editorial Board submitted editorials. As a result of this, a long rebuttal was received from FDA Commissioner Edwards. "Quo Vadis—Medicine?" another piece authored by the chairman, received wide readership.

An attempt has been made to carry a continuing education snap quiz series in the *IMJ*. This would aid physicians in pointing out possible shortcomings in personal knowledge. Unfortunately, no source of materials was obtained to enable publication of this. The Editorial Board did agree, however, that the materials carried in the View Box, EKG of the month, and in certain other regular features were of the same nature as a snap quiz. This will continue in development.

The November issue of the *IMJ* was devoted to papers on Gerontology. Dr. Thomas Tourlentes, Chairman of the Committee on Aging, served as guest editor for those papers. Papers from the Nutrition Conference in October were requested for publication. Continuing features on practice management and investments were reviewed. Future plans call for a new continuing feature article to be entitled "Trauma Center." This will be reported in the same manner as Surgical Grand Rounds and report about meetings conducted through the State-wide Trauma Network. Another proposed series is under consideration, this one on rheumatology. Maternal mortality case reports are on file from the Maternal Welfare Committee and these will be published early in 1972.

The year began with 44 manuscripts pending, it ended with 59. This is a good indication of the value of the *IMJ* and the esteem in which it is held by the people wishing to publish material. It is very seldom that a

paper must be solicited, although this is done when a particularly outstanding presentation is made.

In retrospect, the *Journal* functioned smoothly for 1971. A total of 66 articles were published, 13 of these in the area of general information and the balance in clinical medicine. Within the clinical medicine articles, 15 of the major medical specialties were represented. This achieved good balance and met the needs of the membership which, according to the recently concluded readership survey, indicated that specialists make as much use of the *IMJ* as generalists.

We are happy with the outcome of *IMJ* for the past year and look forward to continuing success in 1972.

Frederick Steigman, *Chairman*

Edward DuVivier

Arthur DeBoer

Joseph H. Kiefer

Clarence J. Mueller

Robert E. Lane

David Shoch

Newton DuPuy

Thomas J. Collins

Arkell M. Vaughn

Edward P. Cruzat

Alon P. Winnie

Theodore R. Van Dellen, *Editor*

Contributing Editors

John M. Beal

Leon Love

John R. Tobin, Jr.

Harvey Kravitz

Neil Allen, *Resident*

William E. Adams, *Consultant*

Editor of IMJ

The *Illinois Medical Journal* served as a medium of expression on a variety of specific topics pertinent to the medical profession this past year as it dealt with special sections on HMOs and FMCs, the statewide trauma network, legislation and geriatrics.

Health Maintenance Organization (HMO) and Foundation for Medical Care (FMC) information presented at the previous year's annual Leadership Conference was abstracted in the January issue to acquaint the membership with these two facets of health care delivery. As a result, after careful consideration of these two systems, the ISMS House of Delegates initiated plans for an Illinois Foundation for Medical Care at the annual meeting in May.

Doctors Bruce Flashner and David Boyd's plan for the organization of a statewide system of trauma facilities to treat the critically injured first gained recognition in the March issue of the *Journal* where the plan was carefully defined and outlined. The proposal became a reality one month later when Gov. Ogilvie announced the state's adoption of the plan. The March issue of the *Journal* suddenly became very much in demand throughout the state as the staff strived to keep up with the demands for reprints of the article.

Special sections of the September and November issues of the *IMJ* were devoted to legislation and geriatrics respectively. The "Report on Legislation" analyzed the key medical legislation enacted or in consideration before the Illinois House and Senate. "Population age 65+" was dealt with in six articles covering such topics as arthritis, psycho-social aspects, and normal aging.

In addition to the special sections this past year, a variety of different clinical aspects of medicine were handled in the form of articles on "The Treatment of Liver Wounds in Viet Nam," "A Report on Diphtheria in Chicago" and "Management of the Patient with Terminal Illness."

Fifty-three articles of a clinical nature were published this past year with 15 specialties of medicine explored. In terms of specialty, surgery and internal medicine articles received the widest coverage, with remaining specialties, such as pediatrics and psychiatry, receiving equal attention.

"EKG of the month," introduced in the January issue of the Journal, and patterned after the quiz-and-answer format of the successful "Viewbox," received a favorable response. "Practice Management News" (written by Robert P. Revenaugh, of Professional Business Management) offered timely information on the economic aspects of medical practice. Another feature, "What goes on," made its comeback this past year, providing readers with the who, what, where, and when information on clinical meetings.

Plans for the forthcoming year, as dictated by the Editorial Board, call for a greater amount of clinical articles in the *IMJ* and a "streamlining" of feature material. A new feature presenting actual case reports from the now functioning trauma network, provided by Dr. David Boyd, our newest contributing editor, will appear quarterly in the *Journal*.

Contributing editors, Doctors John Tobin, Nemickas Ringaudas, Patrick Scanlon ("EKG of the month"), John Beal ("Surgical Grand Rounds") and Leon Love ("The View Box") receive my appreciation for their consistent contribution. My deepest thanks also to Mr. Ott, Mrs. Sloan, Mr. Kinney and staff, who each month do their share in maintaining the *IMJ* as a truly "one-of-a-kind" state medical journal.

Theodore R. Van Dellen, *Editor*

TASK FORCE ON COMPREHENSIVE HEALTH PLANNING

After four years of existence in what appeared to be a semi-conscious state, Comprehensive Health Planning has emerged as a powerful, effective force in Illinois—with little help from ISMS. A review of Illinois CHP highlights in 1971 show that:

1) The General Assembly enacted Senate Bill 475 making CHP statutory. Prior to this, CHP in Illinois existed only as a response to a federal law. Now it stands on its own as a well financed, fully staffed program with the potential for a powerful lobby.

2) The Comprehensive State Health Planning Agency program received a federal allocation of \$280,000. While the state was required to match this only with a 25 percent matching grant, the Governor convinced the legislature to allocate \$300,000, giving the program a total of \$580,000.

3) Assured of adequate financing, the Comprehensive State Planning Agency expanded its staff under George Lindsley, associate executive director, and established additional offices in Chicago and Carbondale as well as Springfield.

4) CHP received an additional shot in the arm when the Governor announced a new regionalization plan for Illinois which defines the frame of reference for the future development of all area and local CHP programs in Illinois. All available money and help will go to these areawide agencies that conform to the Governor's way.

As stated earlier, all this has been accomplished with little help from ISMS. This is unfortunate, because we believe that the future patterns of health care delivery are certain to be influenced by the effectiveness of health

planning activities at the community level. It is, therefore, imperative that ISMS and all county medical societies become actively involved in CHP activities. By this means physicians can retain a direct influence in developing a health care delivery system that will best serve their communities.

To stimulate physicians and county medical societies to assume a leadership role in CHP, the Task Force launched a series of Regional Conferences on CHP and Trauma Centers for physicians in each of the Governor's seven newly-designated regions.

The first such conference—held in Oak Brook January 5—attracted some 56 physicians from Cook, Lake, McHenry, DuPage, Kane, Kendall, Will-Grundy and Kankakee counties. Speakers included members of the Task Force on CHP, George Lindsley, associate director of the Comprehensive State Planning Agency, and Dr. David Boyd of the Illinois Department of Public Health.

The Conferences, which will continue throughout the spring and fall, are designed to:

1. Update physicians on the purpose, functions and objectives of CHP . . . encourage them to participate in their local CHP program . . . and show them how their county medical societies can guide the activities of their local CHP agency.
2. Explain the Governor's new regionalization plan and how it affects their local CHP.
3. Inform physicians about the regional trauma centers and how the centers relate to their particular "region" and hospital.

John H. Kendall, *Chairman*

Thomas deGraffenried
Frank J. Jirka, Jr.
Philip Lynch

E. A. Piszczek
Maynard Shapiro
Fred Z. White

Consultants

Thomas Harwood

Clarke Mangun

Clifton Reeder

TASK FORCE ON PHYSICIAN SHORTAGE AND SERVICES TO MEDICALLY DEPRIVED AREAS

The Task Force on Physician Shortage and Services to Medically Deprived Areas concentrated its efforts on two projects during the past year:

- A) A report to the Illinois General Assembly recommending ways in which the state can help medically deprived rural and ghetto areas attract health personnel to their communities; and
- B) A Doctor's Job Fair to help Illinois communities in their physician recruiting efforts.

Report to General Assembly

Last spring, the Illinois State Senate adopted Resolution 119 urging ISMS to "recommend to the General Assembly the best means by which this state can interest physicians to decentralize their practices by making themselves available throughout the state." In other words, how can Illinois solve the physician shortage problem in the urban ghetto and rural areas?

In the Task Force report to the General Assembly—which Senator Cecil Partee termed "the most constructive I have ever seen on the subject"—the Task Force cautioned the General Assembly that there are no *guaranteed* solutions to the physician maldistribution problem. Theories and constructive ideas based on successful pilot projects, yes! But no guaranteed solutions!

In complying with Senate Resolution 119, however,

the Task Force submitted 11 recommendations to the General Assembly on what Illinois can do to help medically-deprived areas attract health personnel. Since the full text of the Task Force report was published in the December, 1971, *Illinois Medical Journal*, the following recommendations are presented in outline form only:

I. RECOMMENDATION: The State of Illinois should establish a Division of Health Manpower Recruitment in the Commission on Business and Economic Development to work with ISMS in (A) Defining the "medically-deprived" areas and establishing a priority list on which the state could concentrate its efforts of assistance; (B) Providing expert consultation to those communities identified as medically-deprived with the objective of helping them attract health personnel; and (C) Conducting continuing recruitment campaigns to attract out-of-state health manpower to Illinois.

II. RECOMMENDATION: The State of Illinois should finance a pilot project providing a two-way closed circuit television set-up between a physician's office or university center and an outlying area health station. If this proves successful, similar TV set-ups could be established throughout the state to deliver initial patient care to medically-deprived areas.

III. RECOMMENDATION: The State of Illinois should encourage the Health Education Commission of the Board of Higher Education to include motivational research of health personnel in its new "Rand Study."

IV. RECOMMENDATION: The Illinois Department of Registration and Education should be encouraged to notify physician licensure applicants that the Medical Licensure Act requires only one year of hospital training—and does NOT require a rotating internship.

V. RECOMMENDATION: The State of Illinois should encourage establishment of innovative medical education programs to interest students in opportunities available in rural areas, ghettos and small towns.

VI. RECOMMENDATION: The State of Illinois should provide full tuition scholarships and reasonable living expenses for qualified medical students who agree to practice in rural, small town or ghetto areas and for those students who are able and capable of attending medical school but who do not have the resources to do so.

VII. RECOMMENDATION: The State Legislature should continue to provide funds for medical school expansion of clinical clerkships in non-university community hospitals.

VIII. RECOMMENDATION: The State of Illinois should encourage the expansion of residency programs throughout the state and provide the financial assist-

ance necessary to accomplish this.

IX. RECOMMENDATION: The State Legislature should try to increase medical manpower as it applies to post-graduate training by implementing the recommendations of the 1969 Report to the Board of Higher Education on Health Education for the Professions, commonly known as "The Campbell Report."

X. RECOMMENDATION: Where internship and residency programs abroad are deemed comparable to U.S. residency and internships, the Illinois Department of Registration and Education should be encouraged to allow physicians to substitute that training for the required American internship and residency training.

XI. RECOMMENDATION: The State Legislature could make Illinois more attractive to physicians by improving the malpractice climate through the enactment of proposed legislation.

Doctor's Job Fair

On October 24, the Task Force and the ISMS Physician Placement Service co-sponsored a Doctor's *Job Fair* at the Marriott Hotel in Chicago. This was a "first" in Illinois medical history, giving representatives of more than 70 communities the opportunity to meet face-to-face with more than 250 "available" physicians.

The communities—represented by over 350 people—manned exhibits proudly extolling the features of their respective town or county. For several hours the 250 job-seeking physicians strolled through the aisles visiting booths and talking to community representatives. At the end of the program, at least 57 communities received commitments from physicians to visit their areas.

A followup survey revealed that at least five communities solved their problem by "signing up" seven physicians. They were: Geneseo, Woodstock, Rochelle, Chicago Heights and Physicians-On-Call. The Job Fair also proved to be one of the best ISMS public relations projects of the year, for it captured the imagination of news media throughout the country. Besides coverage by Chicago newspapers, radio and TV, the fair was given national coverage by the Associated Press, NBC's "Today Show" and "American Medical News."

William M. Lees, *Chairman*

Fred Z. White, *Vice-Chairman*

Arthur Appleyard, D.O.

Andrew Brislen

Alfred Faber

David S. Fox

Robert Freeark

Jack Gibbs

Allan Goslin

Eugene Hoban

Eugene Johnson

Morgan Meyer

Thomas Reardon

George Shropshire

Donald Stehr

Philip Thomsen

Public Affairs Dinner—March 8, 1972

Economics and Peer Review

COUNCIL ON ECONOMICS & PEER REVIEW

The Council on Economics & Peer Review was active during the year performing its primary responsibility of being the state appeals mechanism for peer review. The Council considered ten cases that had been submitted to it by physicians, patients, or third parties. Each case had previously been heard by a local peer review committee.

Legal Dangers: The experience gained by the Council during its brief history has pointed out possible legal dangers that might result from peer review activities. However, the Council is convinced a meaningful peer review mechanism is vital to the future of organized medicine and that the legal risks involved should not deter the peer review process.

Guideline Modifications: Because of the various kinds of cases being submitted to the Council, it was felt some modifications of the peer review guidelines were necessary. These were prepared, submitted to the ISMS Board of Trustees for approval, and upon approval were to be sent to every county and district peer review committee.

The additions to the guidelines emphasized: that quality care is the prime concern of peer review; that all cases referred for review should be considered regardless of the potential for litigation; that plans or programs of third party carriers may also be referred to ISMS peer review for suggestions or improvement in the quality of care. The Council also made several procedural revisions to the peer review guidelines.

Educational Functions: Another important Council function is its educational responsibility to local county peer review committees. Local committees received periodic copies of the "Peer Reviewer," a newsletter designed to provide county peer review committees with helpful resource information. The Council also obtained Board of Trustees' approval to purchase a copy of the *AMA Peer Review Manual* for each county peer review committee. This helpful two-volume Manual contains actual examples of how various types of reviewed cases were handled.

Local Peer Review: The Council is pleased to announce that as of Jan. 1, 1972, 82 of the 91 county medical societies in Illinois have indicated their plans for doing peer review. Most of these have established a peer review mechanism. A few, because of limited membership, will use the District Peer Review committees.

Advisory Committee to DVR

The Council's Advisory Committee to the Division of Vocational Rehabilitation re-evaluated its objectives dur-

ing the year. It agreed that major emphasis should be given to working with DVR to educate Illinois physicians about the rehabilitation program and also to provide training for DVR Counselors.

DVR Investigation: In compliance with a request from the House of Delegates, the Committee attempted to document specific cases of over-utilization by DVR. This was accomplished by contacting each county medical society secretary requesting cooperation in obtaining such information from local physicians. If a substantial number of cases is reported, the information will be given to an appropriate department of the state with a request for an investigation of DVR. As this issue goes to press, all the replies have not yet been tabulated.

Merging Committee Functions: The Committee considered a suggestion from the ISMS Committee on Rehabilitation Services that the latter absorb the committee's functions because of some overlapping effort. Since the DVR Committee has achieved its initial objectives so far as is possible, it was felt the suggestion from the Rehabilitation Services Committee was worthy of consideration.

A recommendation was made to the ISMS Board of Trustees that the Advisory Committee to DVR be terminated and its function of liaison to DVR be assumed by the Committee on Rehabilitation Services.

Glen E. Tomlinson, *Chairman*

Fred A. Tworoger
Charles E. Baldree, Jr.
Eli Borkon
Stanley Bobowski
Edward DuVivier
John L. Eaton
Maynard Shapiro
John P. Marty

Robert Becker
R. Gregory Green
Earl E. Frederick, Jr.
Burton Jacobson
Robert Muehrcke
Herbert J. Svab
Earl Walker
Don Michels

Consultants

Joseph R. O'Donnell,
Joyce Root, *SAMA*

Fred Z. White
James Whitehouse, *SAMA*

Advisory Committee to DVR Eli Borkon, *Chairman*

Carl E. Clark
Joseph Compton
Harry Grant
Brian H. Huncke

Thaddeus S. Pierce
Aaron M. Rosenthal
Harold A. Sofield
A. Walter Wise

Charles K. Wells, *Consultant*

ILLINOIS DEPARTMENT OF PUBLIC AID

The welfare crisis which confronts both the nation and Illinois is complex and compelling.

Unfortunately, the situation may get worse before it gets significantly better. But out of the crisis, hopefully, there will emerge the public awareness needed to bring about long overdue welfare reforms.

Contributing significantly to the fiscal crisis in state finance has been the increasing costs of welfare, provoked by long-sustained rises in caseloads.

For example, Illinois, during the past two years, has experienced a five-fold expansion in the average monthly caseload increase in Aid to Families with Dependent Children (AFDC). The situation is made more difficult by inflation and the currently recessed national economy which has caused increasing unemployment and reduced tax revenues.

Compounding the state's fiscal problems has been the federal decision to delay implementation of revenue sharing and passage of broad based welfare reforms as encompassed in the proposed legislation popularly known as House Resolution No. 1.

In Illinois, revised estimates in October indicated that unless significant changes were brought about, the IDPA appropriation of \$1.053 billion for the fiscal year ending June 30, 1972 would fall short by some \$180 million. Since the state gets no federal matching funds for General Assistance (GA), some \$107 million of the projected \$180 million deficit would be state money. Further, grant money was projected to become exhausted sometime during May 1972.

Accordingly, the administration and IDPA carefully analyzed several alternatives. A number of belt-tightening administrative decisions had long been in effect but collectively could not begin to produce the resources needed.

There seemed to be no prospect for a state legislative approval of a tax increase for welfare. Other alternatives—diversion of earmarked funds in the state treasury and/or incurring a short-term state debt—were equally unattractive. However, the Governor has not ruled out these options if the Legislature deems it appropriate public policy.

Members of the Illinois State Medical Society are well aware that the alternative finally chosen was to reform two Illinois welfare programs—General Assistance and Medicaid—effective November 1, 1971. In two separate federal court actions, IDPA was enjoined, and at this writing—January 3, 1971—is still enjoined, from carrying out either reform.

Since space is limited, it seems germane to discuss only Medicaid—the option of primary interest to Society members. Basically, the Medicaid reform as originally proposed had four features:

1. A precedent-setting program designed to guarantee more rational use of hospital and nursing home resources.
2. A freeze on reimbursement rates to health care facilities and implementation of a new reimbursement system designed to foster greater responsibility and cost consciousness among providers of health care.

3. A system of "token" or co-payments by patients to give them greater interest in the quality and cost of their own medical care.

4. Elimination of marginal services, including certain kinds of dental and foot care, and restrictions of services mainly to in-patient services for medically eligible persons who do not receive a welfare grant.

It should be kept in mind that the reform features cited pertain to the original effort to reform Medicaid, commencing in November. Elements of the planned features are undergoing some modification, but it seems best to not further discuss program content on the belief that if and when the injunction is lifted, such information will be conveyed fully and expeditiously to members of the Illinois State Medical Society.

However, some background on Medicaid can give needed perspective as to why the reform was proposed. Since Congress enacted the program in 1966, Medicaid has been the most demanding and the most difficult item in financing state government. It has cost much more nationally than the Congress first anticipated. In Illinois, Medicaid accounted for 31 percent of the 1966 welfare budget. It has steadily increased and currently consumes more than 42 percent.

Since fiscal 1966, the annual cost of Medicaid in Illinois has increased by more than 280 percent. The cost in 1966 was \$80.8 million and by 1971, had risen to \$305.6 million.

Reasons for the upward spiral in Medicaid costs are easy to spot, but most difficult to correct. First, the caseload has been rising rapidly. In January 1966, only 252,800 persons were eligible for Medicaid, but in June 1971, more than 856,000 persons were eligible, a jump of 295 percent. Second, the cost of caring for each case is rising rapidly. Studies have shown that the Medicaid program has contributed to the rapid and uncontrolled cost spiral.

Medicaid has subsidized a massive new demand for health care but has failed to increase either the supply of care or control its quality. The rising cost curve has been "literally" vertical. In 1966, the average cost of a day in an average hospital was \$49. In 1971, it was \$88, an increase of 80 percent. In a typical teaching hospital, costs for a Medicaid patient runs \$111 per day, and in one such institution it is \$238.

In fiscal year 1971, more than \$305 million in Medicaid funds were distributed as follows:

Type of Service	Cost in \$ million
Hospital care	\$121.2
Nursing home care	91.4
Physician care	28.0
Drugs	25.9
Clinical and out-patient	17.8
Dental care	10.0
Optometric care	4.6
Podiatry	.4
All other	7.3

Providing the same services in fiscal 1972 would cost \$435, an increase of 41 percent over 1971. However, the appropriation available is only \$335 million. If unchecked, Medicaid expenditures will overrun the appropriation by some \$100 million.

The cost data just discussed should provide some useful perspective on Medicaid reform. The real issue is not to fault any particular group for failure of the present system, but rather how best to come to grips with providing effective health services with limited financial resources, regulating abuses and demands on services, securing equitable federal financing, and improving the quality of care. Working together, we can and must bring about the needed reforms.

There have been a few fiscally hopeful signs since October—improvements in job training money, some additional funds for social services under new federal interpretation, and the possibility of some alleviating federal funds for public assistance. But it is prudent not to overstress small improvements, however helpful, nor count federal interest in new money as a sure thing.

One administrative improvement of interest has been the launching of the Hospital Admission and Surveillance Program (HASP) in an effort to reduce unnecessary days of hospitalization of recipients. HASP emerged through an agreement between the state (by and through the departments of Public Health and Public Aid) and the Illinois Foundation of Medical Care—a not-for-profit corporation. The intent of HASP is to help solve this major health care program through the cooperation of public agencies, private physicians, and medical institutions—all functioning within the context of free enterprise.

Edward T. Weaver, *Director*

ILLINOIS DIVISION OF VOCATIONAL REHABILITATION

Persons with a partial handicap that substantially interferes with work can get DVR help if there is a reasonable expectation of being able to work after one or more of the following services are provided to reduce the handicap or prepare for work:

Vocational Guidance	Psychological testing
Diagnostic Evaluation	Vocational training
Medical, surgical, psychiatric treatment	Transportation or Maintenance
Hospital care	Books and Supplies
Prosthetic or sensory devices	Placement and followup

Financial need is a requirement for all services except Guidance, Training, Diagnosis, and Placement. This State-Federal partnership program has been in effect in this country for 51 years since its start in 1920. Two million disabled persons in the United States have been prepared and placed in almost all kinds of jobs. Thousands of Illinoisians have been helped to overcome such disabilities as arthritis, blindness, orthopedic limitations, mental illness, heart trouble, deafness or hearing difficulties, speech impairments, stroke, epilepsy, among many others.

Disabled people have landed almost any job you can name: Construction worker, warehouseman, mechanic, cleaner and dyer, railroad brakeman, watchmaker, farm manager, trapper, cook, waiter, bookkeeper, clerk, sales-

man, civil engineer, physician, dentist, hotel manager, among many others. In some cases, disabled housewives have been helped to learn better ways of managing a household in cooking, cleaning, and child care. Counselors advise the disabled person and arrange for help for his disability and in preparing for a job.

An important opportunity for employment of blind persons is offered by the Illinois Division of Vocational Rehabilitation's Vending Stand Program for the blind. On sale at these stands are such commodities as tobacco, candy, confections, and food items. Vending stand income compares favorably with that of most small retailers.

An act of Congress provides for certain preference for blind people in the operation of vending stands in Federal buildings and grounds. However, about two-thirds of the stands are in non-Federal buildings and are established with the cooperation of the Illinois Division of Vocational Rehabilitation.

Priority is given to people receiving public aid. The cooperative agreement between DVR and DPA states:

The compelling obligation on human service agencies, as increasingly mandated by governmental agencies and public groups, to develop the economic independence of public welfare recipients, sets the purpose of this agreement. Through a closer coordination and integration of services and with an increased emphasis on services leading to employability, as expressed within the body of the agreement, the cooperating agencies intend to achieve a substantial increase in the number of disabled welfare recipients entering remunerative employment.

OBJECTIVES:

1. To increase substantially the number of referrals of disabled public aid recipients, including Work Incentive Program (WIN) rejectees, with potential for remunerative employment, to the Division of Vocational Rehabilitation.
2. To expedite and enhance cooperative services of both agencies by refining operating procedures and responsibilities in the mutual service contribution.
3. To develop new programs in areas where there is an identifiable need for additional rehabilitation services.
4. To institute an Interagency Planning and Review Committee charged with the ongoing evaluation of the joint program of service and to plan for additional service programming responsive to identified needs.

A total of 1,397 public aid recipients were closed rehabilitated in 1971 at a DVR case service cost of \$1,235,043. Their successful rehabilitation will reduce Public Aid payments by \$933,456 annually. In less than two years, therefore, the cost of DVR services would have been amortized by the reduction in Public Aid payments.

These people rehabilitated into paid employment will earn a projected \$2,969,044—in increased earnings only—annually; this represents a gain of \$39,301 in tax revenue per year to the State of Illinois.

A conservative estimate of the work-life span is 30 years; over this 30-year period, a projected \$1,179,000 would be paid in Illinois taxes by these people rehabilitated into paid employment. Conversely, had these 1,397

people not been rehabilitated, the cost to Department of Public Aid to maintain them on the roles over a 30-year period would have been approximately \$28,003,680.

High priority has been given to services to public offenders; it has been recognized that the present penal system requires a multiplicity of services to return inmates to society as responsible citizens.

It was to achieve this goal of complete and coordinated services that the Division of Vocational Rehabilitation and the Department of Corrections, Juvenile Division, signed a cooperative agreement on September 21, 1971. Prior to signing of this agreement, DVR had recognized and provided intensive services to this area of great service need . . . rehabilitation of the public offender.

DVR provides for services to selected youths in the forestry camps and for those in medium and maximum security juvenile institutions.

A disabled person, instead of being supported by taxes his fellow Americans pay, is himself a taxpayer, once he goes to work. For every Federal dollar invested in his rehabilitation he will return an average of \$5 to the U.S. Treasury in Federal income taxes during the remainder of his working life.

But the most important person to benefit is the disabled person himself. Through this program, he has been enabled to live an independent, productive life.

Alfred Slicer, *Director*

DISTRICT OFFICES

Alton	510 East Sixth Street
Anna	Rural Route 2
Aurora	275 East Downer Place
Belleville	601 South High Street
Benton	Route 37, North
Bloomington	2317 East Oakland Avenue
Carbondale	1100 West Main Street
Champaign	33 East Springfield Street
Chicago (3)	160 North LaSalle Street, Rm. 1020 1525 East Hyde Park Boulevard 6445 North Western Avenue
Chicago Heights	450 West 14th Street
Donville	103 North Robinson Street
Decatur	3130 North Water Street
DeKalb	Brodt & Milner Building, 118 Oak Street
East St. Louis	913 Illinois Avenue
Galesburg	347 East Ferris
Glen Ellyn	799 Roosevelt Road
Greenville	919 East Morris Street
Gurnee	4617 Grand Avenue
Harrisburg	20 South Vine Street
Jacksonville	1440 West Walnut Street
Joliet	702 West Jefferson Street
Kankakee	780 West Merchant Street
LaSalle	535 Third Street
Macomb	Macdon Plaza, 121 Scotland
Charleston	R.F.D. 4, P.O. Box 309
Mt. Prospect	1050 Prospect Plaza
Mt. Vernon	4 Doctors Park Road
Olney	1205 South West Street
Peoria	3179 Northeast Madison
Quincy	2435 Broadway
Rock Falls	1008 Seventh Avenue
Rockford	3809 East State Street
Rock Island	Watchtower Plaza, 910 37th Avenue
Shelbyville	1117 West North First Street
Springfield	330 South Grand Avenue, West

DRUGS AND THERAPEUTICS

The former Subcommittee on Drugs and Therapeutics has attained full committee status. It met several times during the past year to refine the drug list contained in the Drug Manual of the Illinois Department of Public Aid. Countless hours were spent in reviewing physician's requests for drugs not listed in the manual in an effort to keep the Manual current and effective. The necessary deletions and additions were made. As a result of this activity, the new printing of the Drug Manual was made available to physicians and pharmacists in October, '71.

At the present writing, 2,860 written requests for drug usage have been received by the committee. Numerous requests from pharmaceutical companies have been reviewed and action taken at their request.

The Committee concurred with the action taken by the House of Delegates of the ISMS in reference to Resolution 71M-28 (AMA Drug Evaluation) in adopting this resolution. A letter from this Committee to the Council on Drugs of the AMA indicated support of this action. A reply to the Committee reads in part, "*AMA Drug Evaluations* is intended to be a guide for physicians in their choice of drugs. It can never, however, substitute for clinical judgment on the part of the practicing physician in choosing the medication which is best for an individual patient."

One of the recommendations to the Board of Trustees by this Committee suggested that a better liaison be established with the IPhA. This was realized in part when an Ad Hoc Committee comprised of members of ISMS, the IPhA and the Drugs and Therapeutics Committee met on November 10, 1971 to discuss the anti-substitution measure.

In October, 1971, Dr. Henry Holle, who served as a consultant to this Committee, retired as medical director of the IDPA. Dr. Holle's advice and services to this committee were greatly appreciated.

The Committee appreciates the cooperation it has received from physicians as a whole. It welcomes their comments and will be guided by their sound therapeutic suggestions when making recommendations to the IDPA for future revisions of the "Drug Manual."

Robert C. Muehrcke, *Chairman*

Joseph D. Cece

Richard L. Landau

Charles R. Frazer, Jr.

William H. Walton

James L. Hora

Consultants

Louis Gdalmann, R.Ph.

A. E. Livingston

Bruce Flashner

Ninth Annual
Public Affairs Dinner
at the
Illinois State Medical Society
Annual Meeting
Wednesday
March 8,
Williford Room
Conrad Hilton Hotel

Reception 6 p.m.

\$13 per person

Dinner 7 p.m.

\$25 per couple

Education and Manpower

COUNCIL ON EDUCATION AND MANPOWER

The Council on Education and Manpower has addressed itself to many significant concerns in the field of medical education, liaison with medical schools and governmental agencies concerned with medical education, retention of physicians, and subjects introduced by the Committees on Allied Health Education and Continuing Medical Education. Since the last meeting of the House of Delegates the Council has met on several occasions to discourse on these items and to make specific recommendations to the Board of Trustees. It has been a productive period and our gratitude is extended to the deans of the medical schools and their representatives plus many others who have contributed to the work of this Council.

Endorsement of Medical Education Programs: Resolutions 71M-2 and 71M-3 called for several actions, part of which have been considered by this Council. The Task Force on Physician Shortage and the SAMA Advisory Committee will report elsewhere about their part. The House of Delegates, by its action, endorsed MECO as a valuable program and indicated that there should be increased physician participation in the program. A part of these resolutions requested endorsement of similar programs and as a result of this the Council has submitted a resolution for consideration by the 1972 House of Delegates. This resolution would call for support by ISMS of innovations in curricular and co-curricular programs in medical education, either by direct support or by endorsement. Each program, of course, would be reviewed on its own merit and its foundation in the basic sciences should be maintained. The Council felt that the medical society should be on record as supporting programs to broaden the horizon of the medical student and to grant opportunity for exposure to various practice opportunities. In addition, a letter was addressed to the Board of AMA-ERF asking for their consideration of the feasibility of financial assistance to MECO. No response has been received, as of this writing.

71M-35: This resolution from 1971 directed this Council and the Council on Legislation (Governmental Affairs Council) to encourage the executive and legislative branches of the government, the Illinois Board of Higher Education, and the University of Illinois Board of Trustees to expedite a family practice department. This has been accomplished through direct communication with the deans of the medical schools, who have met regularly with this Council, and also through correspondence submitted to the Board of Higher Education and the Health Education Council of the Board of Higher Education. In addition, inquiries were again directed to each of the medical schools asking for a status report on the development of family practice departments. We are pleased to report that all schools have replied, indi-

cating that plans are underway for such a department or a related activity, although no exact date for full accomplishment has been set at some of the schools. Each of the state schools, however, does have a department of family practice in operation as of this writing. **71M-50:** The Emergency Health Personnel Act was endorsed through this resolution and it was indicated that individuals and agencies concerned about this Act should be notified. A letter was sent to each county medical society informing them of this and indicating that as soon as procedures for implementation had been codified by regulation that information also would be circulated.

Physician Retention: Over the past several years data have been developed which indicate that many medical students of Illinois, upon completion of their medical training, leave for other states. According to the Campbell Report as many as 60% leave. It is essential that there be developed a means to retain these physicians. There must be a significant effort made to produce more physicians, of course, but in addition internships and residencies in Illinois must be improved and made more attractive. To accomplish this, more involvement of the community hospitals with the medical schools is essential.

At one time the Council entertained the idea of conducting a survey of practice location motivation. The cost was prohibitive and contact with neighboring states was unfruitful in an attempt to share the cost. As a result, the Council could not engage in this particular activity but it has requested the Health Education Commission to include it as part of the Rand Study.

In further discussing this matter it was agreed by the members of the Council that involvement of the physician with medical students through internship and residency programs, the MECO summer job program, inviting students, residents and interns to their towns, and other activities, are paramount in trying to meet the problem of retaining physicians and maldistribution.

Medical Practice Act: The Council most happily endorsed an amendment to the Medical Practice Act which would remove requirements for citizenship prior to achieving licensure. In addition, amendments which were made to allow advanced standing for prior training of medical students helped to speed up the process of medical education for certain individuals. We commend the Board of Trustees and the Governmental Affairs Council for taking these matters to the legislature and successfully working for their accomplishment.

Senate Resolution 119: Senator Partee introduced Resolution 119 in the Illinois Senate asking that ISMS and the AMA suggest means whereby medical manpower might be more evenly distributed throughout the state, a de-

centralization of practice. Three primary activities were determined and discussed by this Council, which were suggested to the Task Force on Physician Shortage. These were: 1. Decentralization of undergraduate and graduate education; 2. Expansion of medical education as well as allowance for greater enrollments; 3. Motivational research as part of the Illinois Rand Study to promote retention of physicians. In addition, the Council recommended that the formula of the Campbell Report as it applies to funding for development of residencies in community hospitals be studied by the legislature with a view to implementing it.

Policy on Foreign Medical Students: A new avenue for licensure of U.S. citizens attending school in other countries was introduced by the AMA. The policy has been studied by the Council and there are certain reservations. It was agreed that the advanced standing now allowed in Illinois is a mechanism whereby U.S. citizens can gain entry to the medical education process. It will be recommended to the AMA that they review this policy and we will also alert the AMA to the Illinois plan for advanced standing making it possible to accept students from foreign medical schools, placing them at the appropriate academic level.

Relationships with the Medical Schools: Discussion between ISMS and the deans of the medical schools of methods to support activities in development of education and necessary legislation resulted in agreement that there may be a method by which we can collaborate. It was suggested that a small liaison group be formed to formulate activities which would be mutually beneficial, where cooperation would be desirable. This group would study methods for the purpose of bringing forth a common view on finances, licensure, education requirements; to compromise and have joint understanding. Long range programs and concerns could be identified and there would be a working together to bridge the gap between institutions and the practicing profession. This will continue to be studied and recommended.

Allied Health Education

The Committee on Allied Health Education has been concerned with two principal activities.

Physicians Assistants: This question has not been resolved, as there have been several divergent viewpoints expressed by different ISMS Committees and Councils regarding the role of physicians assistants. A special Ad Hoc Committee has been studying this matter to attempt to bring into focus overall concerns and make recommendations regarding education requirements, licensure, and so on. Legislation is still pending in this regard. Interestingly enough, final recommendations of the Ad Hoc Committee very closely parallel the recommendations of the Allied Health Committee made a year ago.

Professional Nurse-Midwives: The 1971 House of Delegates referred Resolution 71M-54, certification of professional nurse-midwives, to the Committee on Allied Health Education for consideration. The Committee reviewed the joint statement on maternity care of the American College of Nurse Midwives and the American College of Obstetricians and Gynecologists. After considering this matter it was agreed that 71M-54 would be an inappropriate resolution to be adopted since it called for legislation to create a certification category of the nurse-midwife. The Committee feels that it is desirable for the state medical society to support experimentation with progressively amplified roles for nurses and other paramedical

personnel. As a result, it would agree with a revision of the resolution being proposed by the Maternal Welfare Committee which calls for endorsement of education programs for registered nurses which would allow them, within their own profession, to gain certification of increased expertise in particular functions. In this regard, a resolution is being introduced by the Allied Health Education Committee calling for rejection of 71M-54. This is not to imply any difference of opinion with the revised resolution being presented for the 1972 House of Delegates on this matter.

Continuing Medical Education

The Committee on Continuing Medical Education has addressed itself to several items. These were primarily in response to Resolution 71M-15. That resolution called for endorsement of the Physicians Recognition Award of the AMA, a continuing awareness of programs in continuing medical education, and study of the feasibility of requiring continuing medical education for continued membership of ISMS.

In completion of the first part of the resolution, a letter was sent to the AMA endorsing the Physicians Recognition Award, as indicated by the resolution.

A review of innovative programs in Continuing Medical Education included those conducted in California, a report on a new two-way television approach of Loyola University Stritch School of Medicine, and the self-assessment program of the Education Resource Center of the University of Illinois. The Committee recognized a definite need for bringing cohesiveness into the programs of many agencies and education institutions throughout the state. We are vitally interested in and concerned with the formation of the Independent Statewide Council on Continuing Medical Education being established through the initiation of Illinois State Medical Society.

The Committee spent most of its time discussing the mechanics of a feasibility study regarding mandatory Continuing Medical Education as a requirement for maintaining membership in the State Society. Of the many opinions this discussion engendered, it became evident that the majority of the Committee felt it may be a *non sequitur* to consider mandatory Continuing Education for membership until the question of the efficacy of current educational offerings is resolved, and that the first step toward the solution of the problems attendant to Continuing Education is to incorporate the principles of Educational Science into program design, planning, implementation and evaluation.

To accomplish these goals, the Committee recommended to the Board of Trustees and the Board concurred, that a grant application be forwarded to the Illinois Regional Medical Program to fund a physician-educator who would have the primary responsibility for the Continuing Education interest of the State Medical Society. He would investigate the efficacy of current educational offering, identify unmet needs and generate programs within the State Society to meet these needs and explore and develop innovative and alternative methods of Continuing Education. This grant application is currently being processed. The person so established would function as part of the Independent Statewide Council.

*(Council and Committee Members
on following page)*

Jack L. Gibbs, *Chairman*
 Herschel L. Browns (Continuing Education)
 F. Howard Clarke (Advisory Comm. to SAMA)
 Donald Stehr (Student Loan Fund)
 Richard Magraw (Allied Health Education)
 Lawrence L. Hirsch Rex McMorris
 R. Charles Oldfield John Holland
 George O. Dohrmann L. P. Johnson

Consultants

Robert T. Fox William M. Lees
 Fred Z. White
 David Lark, *SAMA* Michael Youssi, *SAMA*

Committee on Allied Health Education

Richard M. Magraw, *Chairman*
 Lawrence L. Hirsch William Stewart
 James D. Eggers Peter C. Altner
 Carl Neuhoff Kevin Paulsen, *SAMA*
 Eugene P. Johnson, *Consultant*

Committee on Continuing Education

Herschel L. Browns, *Chairman*
 Dean R. Bordeaux Forrest H. Riordan, III
 Kenneth W. Anderson Robert J. Shafer
 Robert W. Fitzgerald Herbert Sohn
 Leo R. Green Gordon H. Sprague
 William F. Hubble Jerry L. Beguelin
 Mays C. Maxwell Sheldon Waldstein
 John C. Rathe Andrew Thomas
 Kong Meng Tan, *SAMA*
Consultants

George Shropshire Fred Z. White

ADVISORY COMMITTEE TO SAMA

The Advisory Committee to the Student American Medical Association has been primarily concerned with the operation and evaluation of the Medical Education Community Orientation (MECO) project. The third season was completed for 150 students in 56 hospitals in Illinois and the Board of Trustees approved the project for the fourth year.

In May, a post-matching orientation conference was conducted for students and hospital officials. The meeting provided an opportunity for students to meet officials of hospitals where they are to be assigned before they report for duty. The conference was well attended.

Pursuant to action of the 1971 House, the Illinois delegation introduced a resolution to the AMA House of Delegates requesting AMA-ERF to consider financial aid to the SAMA-MECO project. The resolution was adopted by the AMA in June.

An additional project to be considered is a visitation program to be developed in cooperation with the University of Illinois Alumni Association. The program proposes that doctors in small communities in Illinois invite medical students to visit for a weekend to acquaint the students with small town practice and way of living.

T. Howard Clarke, *Chairman*
 Allison Burdick, Jr. Gerald M. Berkowitz
 Nathan Iglitz Kenneth Campione
 Clarence Walton Harold Johnson

John Stutzman
SAMA Representatives

Ronald Ban Donald Batts
 Robert Ljungquist
 Mrs. Edward J. Szewczyk, *Auxiliary Representative*

MEDICAL STUDENT LOAN FUND

There were three highlights of the year for the Student Loan Fund Board:

1. Completion of the Mattson report which revealed that loan fund participants returned to practice in rural Illinois in greater numbers than a control group of randomly selected University of Illinois medical school graduates.

Until this study was made by Dale Mattson, Ph.D., Director of Admissions, University of Illinois, neither the University of Illinois nor the sponsors of the Medical Student Loan Fund knew how effective the program was in achieving its purpose—encouraging Illinois graduates to practice in rural Illinois.

2. As a result of the Mattson report, the University of Illinois agreed to consider for medical school admission any number of candidates that the Loan Fund Board would recommend. On December 11-12, the Board interviewed a record number of students and 23 of these will be admitted to the University of Illinois Medical School in the fall of 1972.

3. The success of the loan program has caused some financial problems which the Board took steps to remedy during the year. Because the number of borrowers increased sharply in recent years and because of the length of time allowed for repayment of these loans, the fund has been temporarily depleted. As a first step toward alleviating this condition the Board voted to cut back the total allowed each borrower from \$7,500 to \$6,000. This amount still allows the student to borrow \$1,500 per year, but only for four years instead of five. Next it asked its sponsors—ISMS and the Illinois Agricultural Association—to lend it \$20,000 each to help bolster the fund until loan repayments match the amount paid out in current loan commitments.

New loans will be made only as funds are available and applicants will be asked for statements of financial condition so that loans will be only made to the neediest. The Board also plans to obtain actuarial advice on the exact number and amount of loans that it can make each year based on its current commitments.

During 1971 four physicians completed their contracts to practice in rural Illinois. One of these is now taking a residency, three others are still practicing in Camp Point, Lebanon and Tremont.

Four 1971 graduates of the program are now interning—one in Chicago, one in New York and two in California. Still in school are eight seniors (including one in Guadalajara, Mexico), 14 juniors, 13 sophomores (including one at the Chicago College of Osteopathy and one at Emory University), and 14 freshmen. Except as indicated, these are all University of Illinois students who have received either a recommendation or a loan from the Board and as a result have an obligation to practice for varying lengths of time in rural Illinois.

Jack Gibbs Donald Stehr, *Chairman* Charles Salesman
 Jacob E. Reisch, *Consultant*

Environmental and Community Health

COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

The year 1971 has been eventful in the field of Environmental and Community Health. This Council has addressed itself to many concerns and the Committees of this Council have several plans in formulation and proposals to be made.

Multiphasic Testing: Screening laboratories have been springing up in many areas. These laboratories may furnish service of use to the physician; it is the collection of facts to help make a medical diagnosis. After deliberating about this matter at several Council meetings, conferring with legal counsel and the AMA Judicial Council, reviewing reports of the Council on Medical Services of the AMA presented at the Annual and Clinical 1971 meetings, a proposal is made to our House of Delegates that it endorse the principle of multiphasic health testing as a matter of policy. Appended to that policy endorsement would be an extended position paper to which reference may be made by all parties concerned with the ethical utilization of multiphasic screening procedures. The Board of Trustees has endorsed the principle of multiphasic health testing as an extension of the physician and the services available to him in making a medical diagnosis. There must be a guarantee of physician involvement and interpretation. Any program should be under the direction or supervision of a physician. Basic minimum standards are necessary. This is a matter of early disease detection not necessarily prevention.

Kidney Protocol: Late in 1970, the Kidney Foundation of Illinois requested endorsement by the State Medical Society of a protocol for early detection of infection and kidney disease in school children. After review it was determined that there were some shortcomings within the proposed protocol. The matter was referred to the Illinois Department of Public Health—Renal Disease Advisory Board. That Board also suggested improvements to the Kidney Foundation. After being revised, the protocol was resubmitted to the Renal Disease Advisory Board and approved. Subsequent to this, the Council also reviewed the protocol and gave approval, which action was supported by the Board of Trustees. After this approval and endorsement, the Kidney Foundation began a series of pilot programs utilizing this protocol to detect disease of the kidneys.

71M-22: This resolution, adopted by the 1971 House of Delegates, instructed the development of universally applicable forms for use in physical examination of school employees. Contact has been established with the Illinois Department of Public Health, the Office of Public Instruction, and the Chicago Board of Health to begin development of these forms. As of this writing this matter is in process.

Trauma Centers: Development of the Statewide System of Trauma Centers under the Department of Public Health was noted by the Council and its Committee on Public Safety. Liaison has been maintained with the program through the Speaker of the House, as well as involving the Director of the Statewide Program with our Committee on Public Safety. As plans for the network are implemented the Council will be alert to them.

Venereal Disease: Upon review of AMA resolution 51 (A71) it was indicated that there was much good to be accomplished through reiterating the necessity for control of venereal disease. This is a serious social problem which should be addressed. The chairman of the Council, as well as other members of ISMS, are working with the Illinois Social Hygiene League in joining the fight. The Council, in considering this matter, proposed that the physicians in Illinois be educated to the necessity for taking cultures rather than smears to detect gonorrhea. This was noted in the *Illinois Medical Journal* and will be a topic for further discussion. Upon the recommendation of this Council the Board of Trustees endorsed the AMA resolution with instructions to this Council to take whatever steps are necessary to continue to inform the members about this matter.

Vaccine Supplies: Unfortunately, state budgetary restrictions forced the necessity of reducing amounts of vaccine available to conduct inoculation programs for children. This could have a deleterious effect on the health and well-being of the population; the feeling of the Council is that the level of immunity to most communicable disease is already too low. The Council is monitoring this and has been making suggestions to various individuals in the Department of Public Health and the Bureau of the Budget to try to help guarantee the availability of biologicals, as they have been in the past.

71M-8: This resolution directed ISMS to encourage the preventive medicine approach to the problem of unwanted pregnancies through encouragement of family life education in the schools, wider dissemination of family planning information, and birth control information. Since this called for development of materials in the school system of Illinois, the action of the House of Delegates was relayed to the Office of the Superintendent of Public Instruction, which office has indicated that it will take our suggestion under advisement as it develops new curricula.

71M-49: This resolution endorsed the concept of outpatient surgery under general and local anesthesia for selected procedures. In addition, it instructed the delegation to the AMA to propose a similar resolution for that

body to consider. It was proposed to the AMA by the Illinois delegation and similarly endorsed.

A recent request from the Illinois Department of Public Health asks ISMS to take a hard look at laws regarding pre-marital examinations by physicians. The certification called for is quite extensive and IDPH indicated the law is not being followed. Some malpractice suits could result if GC tests are not taken. This is a priority item for the Council in 1972.

Child Health

The Child Health Committee has addressed itself to three primary considerations.

Lead Poisoning: During the year there was much press coverage of the findings of screening programs testing children for lead levels exceeding minimums. The Child Health Committee is recommending to the Department of Public Health that centers designed specifically for the treatment and evaluation of children with lead poisoning be developed and integrated into planned or existing community facilities for comprehensive care.

In a related action, the Child Health Committee produced a statement, subsequently endorsed by the Board of Trustees, calling for education of the members of the Medical Society in recognizing and diagnosing lead poisoning. In addition, a recommendation has been submitted to the Bureau of the Budget of the State of Illinois indicating that the lead poisoning detection program should be continued and that the blood drawn for this program be utilized further in determining levels of immunity to communicable diseases. Occasional materials will be developed for incorporation in ISMS publications on this subject.

Rubella Immunization: The Maternal Welfare Committee and the Child Health Committee both evidenced a concern about rubella immunization. Upon receipt of materials developed by the Maternal Welfare Committee, the Council on Environmental and Community Health adopted the recommendation of the Child Health Committee that rubella immunization should be accomplished as follows: School age children (5-12); Pubertal females; Infants (1-5); Women of child-bearing age only after HI test and pregnancy preventive measures. In addition, the Maternal Welfare Committee and the Child Health Committee agree that physicians should consider the advisability of routinely checking patients for rubella immunity and that the test for rubella immunity become an essential part of every patient's pre-marital or initial pregnancy work-up. This matter will be recommended to the membership by the Council, upon proper endorsement of the Board of Trustees.

Smallpox Vaccination: Subsequent to a meeting of the Immunization Advisory Committee of the Illinois Department of Public Health, and the Illinois Section of the American Academy of Pediatrics, a position statement on smallpox immunization was developed. This material was reviewed by the Child Health Committee and was recommended to the Council for endorsement. Upon review the Council did endorse the position statement, with reservation. The Board of Trustees did not endorse the Child Health recommendation in light of AMA action which recommended that smallpox immunization continue to be studied, realizing that an immune population is a desired goal. Only a small percentage of the population has contraindications to routine vaccination.

Athletic Injuries: The Committee reaffirmed the ISMS policy recommending that a physician be present or avail-

able at all school contact sport athletic events. It also feels there is a need for emphasizing, at the college level, training physical education majors capable of recognizing injuries.

Other matters regarding child health were considered by the Committee, as well as other ISMS Committees. These included visual screening programs, sickle-cell anemia, and the Comprehensive Health Education Act of 1971.

Maternal Welfare

During the past year the Maternal Welfare Committee has met and discussed many important subjects. At each meeting, of course, there were reviews of maternal mortality cases reported by the Illinois Department of Public Health. These are surveyed with the intent of preparing educational protocols to prevent the re-occurrence of preventable factors. The review of these cases is done with complete anonymity of the patient and the physician. A series of case reports has been developed for publication in the *Illinois Medical Journal*. One series of reports reflecting teenage maternal mortality in Chicago was published in the March and April issues. Another series has been prepared and submitted to the *Journal* and should be published early in 1972. Additional detailed discussion was held on the subject of abortion. No specific recommendation has been formulated but there is a continuing awareness of this.

Discussion of the role of the Nurse-Midwife was conducted at several meetings. At the 1971 Annual Meeting a resolution was introduced by the chairman of the Maternal Welfare Committee, calling for legislation to certify the nurse-midwife. The matter was referred to the Committee on Allied Health Education. As a result of the deliberations of that Committee it is being recommended to the House of Delegates in 1972 that 71M-54 be rejected. The Maternal Welfare Committee agrees with this viewpoint since it would be erroneous to call for additional legislation to certify the nurse-midwife.

Upon due deliberation it was agreed that a new resolution should be introduced which calls for the Illinois State Medical Society to endorse programs for the training of registered nurses, in a master's degree program, to increase competence in the field of obstetrics.

These nurses would then be qualified to detect obstetrical abnormalities along with high risk patients. They would be able to follow patients in labor and will have achieved a high degree of professional acumen in the detection of emergencies. They will practice under the supervision of a licensed physician at all times. Therefore the Committee wholeheartedly advocates the development of programs for the education and utilization of registered nurses with additional training in the field of obstetrics in which they may be certified by their own profession. A resolution to this effect is being introduced.

The advisability of administration of RHo immune globulin to all RH negative mothers with no previous evidence of sensitization to RHo, who had suffered an abortion or who had delivered an RH positive infant, was endorsed by the Committee. In addition, the Committee considered the advisability of routinely checking patients for rubella immunity. These tests should become an essential part of every patient's initial pregnancy work-up. Your Committee chairman was instructed to attempt to secure an opinion from the State Department of Laboratories as to the availability of rubella im-

munity studies conducted concomitantly with the mandatory syphilis testing. As of this writing, budgetary restrictions and failure to assign high priority on this matter have prevented a successful culmination of these attempts.

Nutrition

The ISMS again co-sponsored the Conference on Nutrition and Medicine with the Illinois Nutrition Committee and IDPH. It was held in Peoria and attendance was excellent. An outstanding program was presented, primarily dealing with obesity, iron supplementation, and food labeling. A future meeting being developed is scheduled for March 29, 1972 in Chicago. It will be the Fourth Symposium on Food Technology, co-sponsored by the Chicago Nutrition Association and the Chicago Section of the Institute of Food Technologists.

71M-46: Resolution 71M-46 called for endorsement by the State Medical Society of the U.S. Department of Agriculture Low Cost Plan. This resolution is not entirely related to matters of nutrition. However, the Committee in 1970 recommended that the IDPA food allowance be increased to conform with the low cost plan of the Department of Agriculture.

The House of Delegates modified the 1970 report to endorse the medium cost plan. Since this was endorsed by the 1970 House of Delegates, it is the feeling of the Committee that the intent of Resolution 71M-46 has already been accomplished. Therefore a resolution is being introduced to file 71M-46.

Diets: During the year discussion has been conducted regarding various fad diets currently in vogue. Unless dieting is conducted under a physician's direction, certain diseases can be aggravated. In addition, the recommended daily adult intakes of nutritious items may not be met. Malnutrition could result. Furthermore, some of the diets are "way out" and death from starvation has been reported. The Committee is commissioning the writing of a manuscript for the *IMJ* on this subject, for the education of the membership.

Vitamin C: The Committee has received inquiries regarding the use of large doses of Vitamin C for the prophylaxis and cure of the common cold. This is largely the result of a recent book by Dr. Linus Pauling. Cur-

rently there is insufficient evidence that ascorbic acid in the doses recommended by Dr. Pauling is either safe or efficacious in the prevention or treatment of the common cold. Until such data are available, ascorbic acid is not recommended for this purpose. This matter will be referred by resolution to the House of Delegates.

Public Safety

The Public Safety Committee has reviewed matters in the area of safety, including such items as implied consent, safety glazing, and snowmobiles. The "Disaster Manual" was completed and distributed to all Illinois hospitals. Several hospitals requested additional copies and requests from various organizations and individuals are received regularly. In addition, the manual was circulated to all County Medical Societies and to various clinics through the Illinois Department of Public Health, which assisted in defraying part of the cost of this publication. The matter of the drivers license medical advisory board was reviewed by the Committee, as well as other legislation, but this particular bill was not passed by the legislature.

Resolution 71M-32: The House of Delegates referred to the Committee on Public Safety, resolution 71M-32, which called for allowing ambulance services in Illinois to exist even though not meeting minimal federal standards. They would be allowed to complement ambulance services being established which do meet minimum federal standards. The Committee agrees with part of the resolution; it would be impractical and unwise to implement the federal regulations immediately and cause some areas to have no service. However, the Statewide Trauma Network and its group of ten regional and 25 local care trauma hospitals, with attendant communication interchange and emergency vehicles, will meet minimum standards. Those ambulance services in existence should be given time to meet those minimum standards, after which all services should be on an equal basis. The Public Safety Committee recommends that all ambulance services in Illinois meet the same standards, once the statewide trauma plan is fully implemented. As a result a resolution is being introduced into the 1972 House of Delegates calling for rejection of resolution 71M-32.

James P. Campbell (Public Safety)
Eugene F. Diamond (Nutrition)
Robert Hartman (Maternal Welfare)
John S. Hyde
Ralph S. Kunstadter (Child Health)
Arthur E. Sulek

Edward A. Piszczek, *Chairman*

Dan Butcher
Howard C. Burkhead (Radiation)
Warren W. Young, *Consultant*
Mrs. William Schowengerdt, *Auxiliary Representative*
Alan Lee Ansel, *SAMA*
Robert Pollnow, *SAMA*

Committee on Child Health
Ralph H. Kunstadter, *Chairman*

Irving Abrams
Samuel Adler
Richard E. Dukes
W. W. Fullerton
Edmond R. Hess
Eduard Jung
Franklin Munsey

Kenneth S. Nolan
T. A. Palus
Norman T. Welford
Lawrence Breslow
J. Keller Mack, *Consultant*
Patricia Dix, *SAMA*
Mrs. Wendell Roller, *Auxiliary Representative*

Committee on Maternal Welfare
Robert R. Hartman, *Chairman*
Frederick H. Falls, *Chairman Emeritus &*
Special Consultant

Districts

Members and Alternates
(alternates in italics)

1. William R. Larsen
Gordon T. Burns
2. William J. Farley
Donald M. Gallagher
3. Melvin Goodman
Charles F. Kramer
4. V. B. Adams
Ralph Gibson
5. William W. Curtis
Robert Maletich
6. Robert R. Hartman
Richard Yoder
7. Paul A. Raber
Hubert Magill

8. John C. Mason Jr.
J. Roger Powell
9. Harry J. Lewis
Donald R. Risley
10. James B. Stotlar
William B. Skaggs
11. John J. McLaughlin
Charles P. Westfall
Consultants
John Louis
Willard C. Scrivner
August Webster
Franklin D. Yoder

Committee on Nutrition
Eugene F. Diamond, *Chairman*

Sheldon Berger
Allen A. Filek
Ben A. Kinsman
Alfred D. Klingner

Philip Lynch
Rene St. Leger
John E. Walters
Robert Mendelsohn

George Shropshire, *Consultant*

Committee on Public Safety
James P. Campbell, *Chairman*

Edward W. Holmblad
Max Klinghoffer
Julius Kowalski
William J. Schnute

Peter M. Wolkonsky
David Boyd
Robert Luther, *SAMA*
Mrs. Wendell Freeman, *Auxiliary Representative*

Ad Hoc Committee on Radiation
Howard A. Burkhead, *Chairman*

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

The Illinois State Board of Health was organized July 12, 1877, with a working staff of three people—an executive secretary and two clerical workers. Its budget was \$5,000 plus \$1,000 for contingencies.

Today, nearly a century later, the Department employs approximately 1,100 professional, administrative, technical and clerical workers who are engaged in a broad range of health services for the state's eleven million residents. Each year the Department administers state and federal funds in excess of thirty-five million dollars.

One reason for this growth is an increasing awareness of the value of public health and the increasing demands for its benefits. The Department assumes additional responsibilities as new health needs are recognized—needs that arise from a burgeoning population with complex health problems.

Program Planning: The Office of Program Planning became operational on April 5, 1971. This office, headed by a Chief of Program Planning, is administratively responsible to the Director of Public Health.

The office was established in recognition of the increasing need to develop and use effective and objective techniques for program planning, including evaluation, control and establishment of priorities. The development and use of these techniques will be of importance in determining clearly defined program goals, specific objectives and subobjectives for the future.

With the organization of this new office, the Department initiated a program which calls for an evaluation

of all its current program activities. The planning unit is charged with the responsibility for developing parameters for the evaluation of long and short-range programs and their objectives within the Department. Such a program is essential to determine objectives and comparative measurements of past accomplishments, current activities and anticipated future activities. Important considerations will include cost effectiveness and need.

The purpose of this effort is to insure the Department's continued provision of responsive public health programs which are relevant to current needs as well as adaptable to future needs.

Community Task Force: The staff of the community task force gives consultation on a continuing basis to any community or professional group in Illinois involved in planning health services or obtaining new or improved health services for the communities they serve.

With the intent of comprehensive consultation to community's efforts, the task force staff operates an information bank on private, state, and federal legislation and financial sources affecting the field of health care delivery. The task force staff seeks to coordinate all governmental efforts in this area, channeling all planning, policy and programs to the specific needs of the community.

Bureau of General Administration: Administering a large organization is a great responsibility. The Department's affairs are kept in order by the Bureau of General Administration. As the general service unit of the Department, the Bureau provides managerial and professional services which are necessary to divisions concerned with specific public health programs. To perform its responsibilities of supportive services, management

and coordination, the bureau is composed of six divisions: Administration, Budget and Fiscal Operations, Electronic Data Processing, Education and Information, Local Health Administration, and Public Health Laboratories.

Bureau of Personal and Community Health: The Bureau of Personal and Community Health is charged with the responsibility of administering the health care and disease control programs of the Department of Public Health. Programs within its jurisdiction include both those designed to prevent illness and disability and those for insuring quality care when it becomes necessary. To accomplish these functions, the bureau is divided into seven divisions. These are Chronic Illness, Dental Health, Disease Control, Emergency Medical Services and Highway Safety, Family Health, Health Facilities and Nursing.

Bureau of Environmental Health: The Bureau of Environmental Health is responsible for programs in which evaluation and control of environmental conditions is necessary to protect the health and lives of Illinois citizens.

Inspection and consultation for program effectiveness are conducted through the seven branch offices, each of which has technical staff members acting as bureau representatives. The field of environmental health is becoming increasingly complex with the public expecting assurance that their health and well-being is protected. The bureau provides this assurance with programs in the following divisions: Food and Drugs, Milk Control, General Sanitation, Radiological Health, Swimming Pools and Recreation.

New legislation affecting the Bureau of Environmental Health was enacted by the 77th Session of the General Assembly and those enactments now signed into law by the Governor include a recreation camp law, a youth camp law, a mass gatherings law and amendments to the current trailer park and migrant labor camp laws. In general, this new legislation authorizes the Department to prepare rules and regulations for sanitary controls to protect the health of the citizens of the State of Illinois.

Advisory Boards of IDPH

- BOARD OF PUBLIC HEALTH ADVISORS
- ADVISORY BOARD CANCER CONTROL
- ADVISORY BOARD FOR CLINICAL LABORATORIES AND BLOOD BANKS
- ADVISORY COMMITTEE ON HAZARDOUS SUBSTANCES
- ADVISORY HOSPITAL COUNCIL
- HOSPITAL LICENSING BOARD
- IMMUNIZATION ADVISORY COMMITTEE
- MIGRANT LABOR ADVISORY COMMITTEE
- ADVISORY BOARD NECROPSY SERVICE
- ADVISORY LONG TERM CARE COUNCIL
- RADIATION PROTECTION ADVISORY COUNCIL
- RENAL ADVISORY BOARD
- OHIO RIVER VALLEY WATER SANITATION COMMISSION
- TUBERCULOSIS ADVISORY COMMITTEE
- LASER ADVISORY COMMITTEE
- ADVISORY COMMITTEE FOR THE CHILD HEARING TEST

Conclusion

The Illinois Department of Public Health is a multifaceted organization designed to serve the public health needs of all the people in the state.

We welcome your requests for more detailed information about the Department or any of its programs.

Franklin D. Yoder, M.D., M.P.H., *Director*

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

The health related responsibilities and functions of the Department of Children and Family Services fall into these general categories: (1) provision of preventive and remedial health care for children who are wards of the Department; (2) implementing provisions of the Abused Child Act; (3) assurance of the health of children enrolled in the Department's residential schools for the visually, hearing, and orthopedically handicapped; (4) developing and assuring compliance with standards for health and safety in the child care facilities licensed by the Department; (5) provision of specialized habilitative and rehabilitative services for adult visually handicapped; (6) assurance and/or provision of medical and nursing care for war veterans, and their wives or widows, in the Department-operated Illinois Soldiers' and Sailors' Home.

Department policies and regulations specify the standards and procedures for promoting and maintaining the physical and emotional health of the children and adults served by all of the Departments' programs and facilities. These were prepared with and implemented under the guidance and advice of the Department's Public Health Officer.

Child Welfare

The Department provides direct child welfare services, meaning public social services which supplement or substitute for parental care and supervision for the purpose of: (1) preventing or remedying or assisting in the solution of problems which may result in the neglect, abuse or exploitation of children; (2) protecting and caring for homeless, dependent or neglected children; (3) protecting and promoting the welfare of children, including the strengthening of their own families and counseling of family members; (4) providing adequate care of children away from their homes, where needed, in foster family homes or day care or other child care facilities; (5) providing counseling for mentally retarded, physically, and socially handicapped children and their parents when not otherwise available.

Of the 27,000 children currently under care, some 23,000 of them are under the guardianship of the Department. These wards are provided preventive and remedial health care as well as medical treatment essential for the cure or amelioration of illness, disease, injury or pathology, and corrective and restorative dental treatment.

Preventive health care consists of periodic physical and dental examinations at intervals generally prescribed in the fields of pediatrics and dentistry. Complete physical examinations including all necessary laboratory procedures are provided or assured prior to placement. Routine physical examinations for children one to 21 years of age are provided annually or more frequently if indicated by medical findings. For infants up to one year of age, usually the physician sees the baby monthly for the first six months and immunizations are administered as part of well-baby care.

Each child receives immunization against communicable diseases. Each child, three years of age and older, has a dental examination and prophylaxis, if indicated, every six months.

Most Department foster children are eligible for Department of Public Aid medical assistance through the MANG (Medical Assistance No-Grant) program. This

includes payment for all services and procedures authorized by that program. However, the Department of Children and Family Services provides all preventive health care services without regard to eligibility for MANG, including routine physical and dental examinations and immunization. The effects and problems connected with MANG will be noted later.

The Department places children in facilities under its own supervision and purchases services from voluntary agencies and institutions. In the latter situation, the same policies and procedures for health care apply. When appropriate, maximum utilization is made of other public agencies such as the University of Illinois, Division of Services for Crippled Children.

The Abused Child Act, which became effective on July 1, 1965, requires practitioners in named medical professions and hospitals to report certain cases of suspected physical abuse, neglect, injury or malnutrition to the Department. In July, 1971, reporting of deaths of children from suspected abuse before they are found or brought to a hospital, was added to the Act. A Central Registry of cases is also required by the Act.

From July 1, 1965, through June 30, 1971, there were 3,424 cases in the Registry and of these, 204 involved deaths, either at the time of or subsequent to the reported incident. Department staff must investigate and offer services when a case is reported. A detailed study of the first year under the Act, July 1, 1965-June 30, 1966, revealed that in providing services, medical resources were frequently used, such as psychiatric, psychological, homemaker, and public health nursing.

Close working relationships between the Department and the various health professions and facilities are essential to the implementation of the Act.

Guardianship Administrator's consent required for major medical . . .

To protect all concerned, when *major* medical, dental, or surgical procedures are to be performed on wards (less than 18 years of age) of the Department of Children and Family Services, the consent of **only** the Department's Guardianship Administrator should be secured. Social workers, foster parents and institution representatives have no authority to sign such consents. The Guardianship Administrator has, by authority of law, designated three other Department executives in Springfield to act in his stead at such times as he may be unavailable. Thus, proper consents may be secured at any time, day or night, 365 days a year. For emergency consents the Guardianship Administrator or his authorized agent may be reached by telephoning 217-525-6533 during business hours, and 217-525-2367 (answering service) after business hours or on weekends and holidays. Consents that are telephoned or telegraphed will be followed automatically with written consents. Written consents by the Guardianship Administrator will be provided in those cases of a non-emergent nature and which can be scheduled in advance. Requests for non-emergency consents should be channeled through the individual child's caseworker.

There are, of course, a variety of other programs and services in child welfare which do not involve the Department with health care to the same extent nor in the same manner as above. For example, homemaker services may be provided to assist a family during a

period of crisis to maintain the children and the family unit in their own home and not infrequently illness or a major illness or disability of the parent is a basic reason for needing homemaker services. Family services other than homemaker to families rather than for a particular child or children in the family are provided in order to strengthen and maintain the family unit. Sometimes there are health problems for which the Department arranges the needed services.

In the program for unmarried mothers, which protects and promotes the welfare of mother and child, the Department provides counseling to assist in planning for the mother's future and in reaching decisions and plans for the infant, as well as arranging for medical care and providing maintenance as needed.

The most recent program, family planning, was initiated in April, 1971. This counseling is available to all families, unmarried parents, and wards for whom the Division of Child Welfare provide services. When the families or unmarried parents are unable to assume the medical costs of family planning (physician prescribed contraceptives) or such services are not otherwise available in the community, or the family is ineligible for MANG, the Department will pay the fees. Use of family planning services is voluntary and does not affect other services the Department may provide these families.

The Department licenses child care facilities under the Child Care Act. Standards developed in accordance with the Act include those which will insure the health and safety of children. The requirements are appropriate to the type of facility and include health standards applicable to the caretakers as well as the children served. The facilities include: foster family homes, adoptive homes, day care centers, foster family day care homes, children's institutions, child welfare agencies, and maternity centers.

Residential Schools for the Physically Handicapped

The three schools, Illinois Braille and Sight Saving School and Illinois School for the Deaf, both in Jacksonville, and Illinois Children's Hospital-School, Chicago, require children to have physical examinations and immunizations prior to admission and at certain other specified times. Since these children are in residence, services and facilities are maintained to handle minor illnesses, injuries or other physical emergencies. Parents or guardians are responsible for medical, dental or any other health services except those that would be normally provided as a part of residential living.

Illinois Children's Hospital-School is exceptional since its purpose is the education of severely orthopedically handicapped children. Therefore, in or available to the School must be a comprehensive range of medical and related specialties. Although staff includes two full-time physicians, most of the physicians and dentists who care for the children are consultants regularly attending on either a fee or free basis. Noteworthy is the fact that the physical facilities are specially designed for these children and include X-ray, dental, and laboratory equipment as part of the medical unit.

Illinois Soldiers' and Sailors' Home

With more than 800 members on the rolls and the median age of 73+, it is quite apparent that the same trends that have affected the aging population generally

are even more significant to the Home at Quincy. There are fewer whose needs are for domiciliary care and more, by far, than can be taken care of, needing long-term nursing care.

Among the requirements for admission is one that states that the applicant "is not mentally ill, or suffering from active or suspected tuberculosis, highly contagious diseases, or any condition that precludes being safely housed with aged or infirmed persons." But this is a minor point as far as health care is concerned since the reasons for the admission and continued stay in the Home mean that there must be a full range of medical and health services provided or available.

Complete care is provided in the medical units by five staff physicians, registered nurses, licensed practical nurses, and male and female medical attendants.

A particular point should be noted. A 200-bed nursing care unit is under construction and should be completed for occupancy in the fall of 1972.

Visually Handicapped Adults

Two programs for the adult visually handicapped have a minimal concern for the physical health of the individual served, but are directed toward the achievement and maintenance of individual social and emotional well-being. Community Services for the Visually Handicapped reaches individuals in their home communities through

home teachers or counselors who provide a range of services individually or in groups. Included are such services as mobility training, homemaking skills, braille and other means of communication, and the like.

The Illinois Visually Handicapped Institute is a specialized rehabilitation center providing evaluation and training according to the needs of the individuals coming to the center. Social, psychological, medical, and occasionally, psychiatric examinations are part of the evaluation. If the people then go on into training, individualized programs are developed for them and the aforementioned services are available and used as appropriate in connection with the training.

In addition to utilizing general and special medical consultations, the physical well-being of the people at the Illinois Visually Handicapped Institute is emphasized through skillfully developed physical therapy, physical education, and physical recreational activities. This has been found to be particularly important to the improvement and maintenance of health of blind people. The program was further reinforced by the recent completion there of a four-year research project on "Postural Determinants in the Blind," conducted by an orthopedic specialist with a grant from the U.S. Department of Health, Education and Welfare.

Edward T. Weaver, *Director*

REFERENCE COMMITTEE MEETINGS

Tuesday, March 7	7:00 p.m.
Officers and Administration	Rm 413
Constitution and By-Laws	Rm 418
Finances, Budgets and Publications	Rm 419
Governmental Affairs	No 2
Education and Manpower	No 4
Economics and Peer Review	Parlor B
Public Relations and Miscellaneous Business	No 3
Environmental & Community Health	Rm 415

BOARD OF TRUSTEES MEETINGS

Monday, March 6	6:00 p.m.	Beverly Room
Tuesday, March 7	8:30 a.m.	Bel-Air Rm
Wednesday, March 8	8:30 a.m.	Bel-Air Rm
Thursday, March 9	8:30 a.m.	Bel-Air Rm
Friday, March 10	6:00 p.m.	Beverly Rm

Finances and Budgets

REPORT OF THE SECRETARY-TREASURER

House of Delegates Minutes

At least once each year, a democratic body consisting of elected representatives of the members, the House of Delegates of the Illinois State Medical Society, meets for three days to study and discuss matters relative and pertinent to their mutual interest and welfare. From these deliberations come conclusions and decisions representing agreements of the majority—which become the policy of the Society for the next year.

To insure accuracy of the actions of the House of Delegates, a complete stenographic record of each House session is obtained. As Secretary-Treasurer of the Society, I have reviewed the 1971 transcript to verify its accuracy and completeness. Any Society member who also wishes to review this record may do so upon request to the Secretary-Treasurer or the Executive Administrator. The 1971 transcript consists of 366 pages.

The day prior to the opening of the regular session of the 1971 House of Delegates, there was a special called meeting of the House to consider the establishment of the Illinois Foundation for Medical Care. The transcript of the proceedings of this session, establishing positive affirmative guidelines and basic principles, is 40 pages long.

So that the delegates could have the major actions of the 1971 House quickly available, to enable them to inform all members of their local society of the work of the House, an edited resumé of the actions was mailed to each delegate within one week following the meeting. In addition, the July 1971 issue of the *Illinois Medical Journal* contained an abstract of the transcript for the benefit of each ISMS member.

As has been the custom in the past, the abstract form of the 1971 minutes will be presented to the 1972 House of Delegates for approval.

New and Innovative

Two projects of major and innovative stature were developed during 1971.

First, after several years of discussion but no action, plans for the unification of the Chicago Medical Society Clinical Conference and the Annual Meeting of the Illinois State Medical Society into a jointly-sponsored meeting became a reality. Throughout 1971 an ISMS-CMS Joint Management Committee has been meeting to establish methods and plans, and staff of each organization has held additional implementing meetings. Advancement of the meeting date to March 7-11, 1972, caused some problems relative to reports, fiscal year statements and other dated events, but such was necessary in order to

obtain adequate hotel reservations. In fact, the meeting dates for this meeting will undoubtedly vary considerably for the next three or four years; later a stable date can be guaranteed by the hotel.

The amalgamation of these two meetings is indeed a milestone in Illinois medical activities and should lead to an outstanding event, with greater participation by both technical and scientific exhibitors and result in a much larger physician attendance.

The **second** outstanding event has been the development and organization of the Illinois Foundation for Medical Care.

Following approval by the 1971 House of Delegates, many have been the hours contributed by the officers, Executive Committee, Board of Directors of the Foundation and several ISMS staff members in developing by-laws satisfactory to both ISMS and local foundations already established or in the process of development.

Urgency was added to the organizational procedures in mid-September when the State of Illinois requested ISMS to develop a *Hospital Admission and Surveillance Program (HASP)* for Public Aid recipients. Several ISMS staff members and Foundation resource personnel worked "around the clock" for approximately two weeks to meet the plan submission deadline. Implementation of the program was set for early 1972. Development of this statewide Foundation for Medical Care, to work in liaison with and cooperatively assist local or regional Foundations, brings Illinois into national recognition in the newer and more efficient methods of delivering health care.

Leadership Conference

Leadership Conferences, one-day meetings packed with voxpop discussions of issues and problems concerning present day complexities of medical practice, have become one of the most popular and effective means of communication so far developed by the Society. Attendance at these Conferences is second only to that of the Annual Meeting.

The 1971 Conference was held November 7 at the Continental Plaza Hotel in Chicago. This year's Conference featured two subjects. The morning session presented *Innovations in Health Care Delivery*, while the afternoon featured a *Confrontation Debate* by representatives of the AMA and a panel of opposition groups.

The first panel in the morning had *Neighborhood Health Centers* as the topic of a discussion by Dr. Harry P. Elam, former medical director of the Mile Square Center of Chicago, and Dr. Leon Reed of East St. Louis.

Health Maintenance Organizations, the so-called "darlings" of the health planners, were the subject of the

next panel. Dr. Mortimer Adler, Vice President and Medical Director of Illinois Blue Shield, discussed the Model Cities project in Carbondale, Ill., for which Blue Shield serves as underwriter. Dr. Mervin Shalowitz, medical director of Intergroup Prepaid Health Service, Inc., discussed his organization's plan for the Chicago area. And finally, Emil Stahlhut, administrator of the Lincoln Memorial Hospital in Lincoln, Ill., described plans for a hospital-based prepaid system in Lincoln.

Emergency Service Plans was the topic for the last panel of the morning. Dr. Gene Gaertner, president of Physician-On-Call; Dr. Jordon Scher, president of Health Maintenance Systems, Inc.; Dr. Marjorie Smith of Medical Emergency Service Associates; and Dr. Robert Blumstein, medical coordinator of Comprehensive Medical Associates, described their various organizations and explained how emergency rooms were staffed and services rendered.

Dr. Joseph O'Donnell, president of the Illinois Foundation for Medical Care, gave a progress report on the Foundation and explained the HASP program.

Luncheon speaker was The Honorable Edward J. Derwinski, U.S. Representative from Illinois, who spoke on the necessity of maintaining a united front in the political wars of Washington.

The afternoon session was billed as a confrontation, and confrontation it was. Drs. Russell Roth, James Sammons and Edward Annis of the AMA debated with Dr. Charles Pfister, President of the Catholic Physician's Guild. Dr. William Towne, President of the Associated Interns and Residents of Cook County Hospital, Mr. Bruce Fagel, National President of SAMA, and Dr. Nobel Correll, representing the Council of Medical Staffs. For some two hours Drs. Annis, Roth and Sammons were engaged in debate, moderated by Dan Price of the Extension 720 radio program.

The debate was videotaped by the AMA and plans are being finalized for this tape to be made available to state and county medical societies throughout the country.

Condolence Letters

ISMS has continued to send an individually typed and personally signed letter of condolence, properly worded to fit the occasion, to the families of all deceased members. Many gracious and appreciative replies have been received from these expressions of sympathy.

Other routine personalized and individually signed correspondence has been sent to each member elected to emeritus, retired or cancellation of dues status.

1971 ISMS Illinois State Fair Exhibit

The 1971 ISMS Illinois State Fair booth featured exhibits on *Drug Addiction* and *Venereal Disease* in colorful visual displays and ranked equally well with two other outstanding previous presentations, "Life Begins," in 1958 and "The Transparent Twins" in 1962. Its impact and effect possibly even surpassed these earlier exhibits in that the '71 display dealt with two current subjects of major public interest.

Much lay interest was generated by two series of factual slides—40 each—on Drug Addiction and VD, which ran continuously 12 hours per day, and the distribution of six types of literature on the same subjects.

The Drug Addiction slide series urged both prevention and treatment of drug abuse. Most of the slides in this

series were specially prepared to answer questions in the minds of this audience and also demonstrated ISMS activity and concern in this field. The slides were supplemented by a "Drug Tower" where many answers to drug questions could be found.

The VD slide series called attention to the dangers of venereal disease, its rapid increase, and an ISMS plea for early detection and treatment. The Society is indebted to Pfizer Laboratories and the Division of Communicable Diseases, Illinois Department of Public Health, for many of the slides; others were especially made—to appeal to the teen-age group.

Over 20,000 pieces of literature, plus over 10,000 of the ever-popular ISMS Health Information Cards, were distributed.

The VD pamphlet, especially designed, prepared and printed by ISMS, was extremely popular. It is estimated that well over 50,000 of these leaflets could have been used (if they had been available), since there were many requests for quantities of 50 to 100 by teachers and others in the education field. Similar requests were made for the other VD literature supplied by the State Department of Public Health.

The 10-page Drug Addiction brochure created equal interest and was high in demand. Again, teachers, PTA groups, Boy Scout leaders, etc., were most anxious to obtain these in quantities. Our supply of 6000 this year came from Blue Shield-Blue Cross.

It is estimated that 50,000 people (5000 x 10 days) passed through the exhibit.

Membership Records System

ISMS has just completed its sixth year of direct dues billing and collection system. Each year has seen improvements in this system, both in accuracy and on a time-savings basis. Results of this are greater yields of a greater number of accurate and varied dues payment reports on a well-scheduled basis. For 1972, 74 component societies have availed themselves of the complete billing service and printed dues forms have been provided for 16 others for their local handling.

The computer program accomplishes much more than dues billing. It generates many sets of membership address labels each month, and the continued use of a carbon technique provides multiple copies at an extremely low cost per label. As stated in previous years, the Society owns no data processing equipment of any kind. Data are prepared on a master tape file, which is the property of the Society, and which can be used on any of the latest makes of computers now in general use. The master tape is designed, if and when the need arises, to store much more information than it now contains, the only cost being that of the necessary programming. It is anticipated that during the coming year our master tape may be used to prepare information pertaining to the Illinois Foundation for Medical Care.

In addition to the above, rosters of members are prepared periodically in a variety of formats for internal reference, thus enabling staff to perform a myriad of assignments not possible prior to the introduction of this system. During the past year, by grouping and timing tape input and corrections, tape maintenance costs have been reduced considerably.

Membership records are now 100% computerized. In addition, the membership of the Illinois State Medical Society Woman's Auxiliary and the Illinois Medical Assistants Association have been added. These two organi-

zations are provided mailing labels and rosters as they are needed. Also provided, almost on a daily basis, is the medical education number of Illinois physicians to pharmacies and other institutions to facilitate their filing state and federal forms, such as for the IDPA. If matters such as this had to be handled manually, much additional staff time and labor would be required.

Membership Statistics

Changes in membership statistics for the past six years are indicated in the accompanying table.

Changes in the number of Society members are subject to many and varied outside influences, such as the attractiveness of Illinois as an environment for medical practice and the general economics and population growth of the state. Membership has continued approximately the same over the past three years. It is regrettable that Illinois educates a sizable number of physicians (with

Illinois tax dollars) who later elect to practice elsewhere.

No Illinois physician, whether in governmental, administrative, industrial or active practice, should feel that he can permit himself the luxury of not playing an active personal role and having a voice in medical society affairs. His participation is needed in order to avoid the splintering of influence that leads to unsound changes in the role of the physician in society. All too often it is the voices of non-members that are loudest and most critical, yet they do nothing to unify their convictions; their impact and constructiveness becomes but a whisper. With all levels of government so deeply involved in the distribution of medical services, the State Society must be the unified speaking voice of the physician, if a voice is to be heard and recognized. This should be examples of the highest degree. They owe the profession, in general, this obligation. Unfortunately, many choose organizational isolationism.

Membership Statistics

Changes in ISMS membership statistics for the past several years, as recorded in the Society's records, are indicated in the accompanying table.

	1971	1970	1969	1968	1967	1966
Membership as of January 1	10,692	10,650	10,627	10,568	10,607	10,626
New Members	426	354	370	425	515	517
Reinstatements	27	28	46	40	43	65
Total added	453	382	416	465	558	582
Dropped during the year:						
Died	146	145	190	205	211	191
Moved from State	49	73	66	50	151	172
Resigned	37	12	13	6	12	21
Nonpayment	121	110	124	145	223	217
Total dropped	353	340	393	406	597	601
Membership as of December 31	10,792	10,692	10,650	10,627	10,568	10,607
Regular	9,399	9,405	9,389	9,375	9,335	9,417
Residents	276	207	223	196	214	250
Service	63	126	101	105	59	51
Emeritus	514	463	472	507	514	484
Retired	484	456	434	403	399	349
Hardship	56	35	31	41	47	52
Intern						4
Total	10,792	10,692	10,650	10,627	10,568	10,607

Financial Statements for 1971

The preliminary December 31, 1971, Year End Financial Report of ISMS (prior to audit) containing the 1971 and 1972 budgets are to be mailed to each delegate by February 7, 1972. This will enable delegates to review the Society's financial position, results of operations, and future planning before the actual Reference Committee hearings. It should be noted that the detailed final audit report prepared by Peat, Marwick, Mitchell & Company for the year ending December 31, 1971, will not be

available in time for the House of Delegates but will be mailed to all members of the House upon completion.

As each physician must know from experience in his own practice, the Society has been experiencing a steady increase in "the cost of doing business" because of inflation. The November release from the U.S. Department of Labor shows the Bureau of Labor statistics index 3.5% above the level of a year ago. Operating within a fixed income over a number of years has become increas-

ingly difficult, and in 1971 some activities had to be curtailed; a few eliminated.

A full in-depth study and report on the ISMS Reserve Fund investments has been prepared by A. G. Becker & Company, a brokerage house and was presented in detail to the Finance Committee on December 12, 1971. The report compared the ISMS Reserve Fund investments by Continental Illinois National Bank with similar funds in size, market timing on buying and selling of stocks, and market performance of funds.

A summary for both a cumulative eight-year period and 1970's performance by itself are presented here for the benefit of the entire membership. It should be noted that ISMS ranked in the top third of the total fund return over the cumulative eight-year period.

A copy of the projected budget for 1973 will be provided each member of the House in advance of the 1972 convention. As stated in previous years, should the House of Delegates direct any new programs of a major nature, a recommendation as to the method of providing the necessary finances for them must also be provided by the House at the same time. For 1972 this becomes more important than at any previous time, since the implementation of any sizable project can be accomplished only by the curtailment or deletion of some current activities. The Board of Trustees will recommend a course for 1973 at the concluding session of the 1972 House of Delegates.

Cumulative Performance Summary 1963 Through 1970

	Total Fund Return	Equity Commitment	Equity Return	Fixed Income Return
Maximum	8.83	97.0	11.48	5.46
First Quartile	6.40	75.2	9.35	3.23
Median	4.60	61.9	7.40	2.32
Third Quartile	4.20	53.4	5.82	1.59
Minimum	2.68	41.4	4.37	-0.67
Your Fund	5.51	62.8	7.45	3.07
Your Rank	8	9	11	9
Number of Funds	24	24	23	20

Annual Performance Summary 1970

	Total Fund Return	Equity Commitment	Equity Return	Fixed Income Return
Maximum	12.03	96.4	11.50	16.99
First Quartile	3.90	76.6	-0.33	12.08
Median	0.43	66.9	-2.59	10.22
Third Quartile	-2.64	60.3	-5.88	6.91
Minimum	-20.37	38.1	-20.12	-8.40
Your Fund	10.46	74.4	11.50	7.78
Your Rank	3	17	1	33
Number of Funds	50	49	49	48

SOCIETY SERVICES AND BENEFITS

Benefits of the Society and its services to the membership are all too often accepted routinely and without full realization of their value. While many of these are well-defined in an excellent brochure completed by the Public Relations Division in 1970, there are numerous others which are helpful and beneficial in every member's daily practice. A non-inclusive random listing of these are noted in the following casual survey.

First, a Membership Packet is made available to each new member. Included are six sections: Introduction to ISMS, Insurance and Retirement Plans of ISMS, ISMS Publications, Educational Materials of ISMS, Other ISMS Services and County and AMA Materials, a total of 32 informational pieces.

Other Society services provide:

- A "Physician's Liability Booklet," developed in 1970, which has been distributed during 1971 upon request.
- A "Disaster Manual," now in its third edition, has been compiled by the Public Safety Committee. It is a guide for hospitals and physicians to use when planning for coping with major disasters. Present distribution amounts to 632.
- A "Medicine and Religion Booklet." Only State Society to develop such. In two years, over 18,000 copies printed.
- "On the Legislative Scene." Published weekly while legislature in session. Gives review of past week's activities regarding medical legislation considered by General Assembly.
- "Governmental Affairs Digest." Published monthly when the Illinois General Assembly is not in session. Reports information on what is happening in government and politics.

- Health Insurance Council (HIC) forms. A standardized form for handling insurance claims. Distributed for several years. During 1971, a total of more than 50,000 forms were sent out.
- Consent forms for patients using "The Pill." Designed on advice of legal counsel. Within the first three-month period, 8,923 forms were mailed.
- Informational material concerning U.S. Controlled substances Act of 1970 and Illinois Control Substances Act of 1971 circulated to all county medical societies; also published in *IMJ* and "Pulse."
- The Doctors' Job Fair—October 24, 1971. A tremendous success. Over 70 communities and 225 physicians attended! To date, eight physicians have been placed in rural Illinois as a result.
- At least one, and on occasion two, Leadership Conferences during each year. Open discussion meetings on vital subjects such as Medical Liability, Peer Review, Foundations for Medical Care, Legislation. Attendance second only to Annual Convention.
- ISMS Placement Service. Over 500 physicians and approximately 450 towns, communities and clinics are registered.
- 1971 MECO Project. Ongoing since 1969. This year (1971), participation of 45 hospitals and 165 students.

In addition, the State Society:

- Annually publishes the "Reference Issue" of the *IMJ* to inform the membership of services available, to indicate areas of ISMS activity and the members developing such activities, to reference state of Illinois and medical education services—

a compendium of over 150 pages of useful information to assist the member in his practice.

- Provides many staff services to the Auxiliary and assists in their communications to their membership, also furnishing space in ISMS publications and developing computerized mailing lists and labels.
- Through an ISMS Peer Review Committee, serves as the appellate body for all county and district Peer Review committees which assists in maintaining high standards for medical care throughout Illinois.
- Provides Benevolence, a kind word, the password of the committee bearing that name. Supplying minimal needs to members and their survivors in their later years when unkind economic toll has necessitated financial assistance, this unheralded activity is basic to the tenets to which the medical profession holds and upon which the society was founded.
- Was the first state medical society to recognize its member physicians who have practiced fifty years and to honor them with an annual luncheon and membership in a select group.
- Serves as a clearing house of information on medicine, health, licensure, education and other similar matters.
- Provides advice and guidance to voluntary health agencies.
- Maintains a Scientific Speakers Bureau for county and branch societies, or professional groups, to continue to upgrade medical knowledge.
- Sponsors various insurance plans, including malpractice, and maintains liaison with carriers.
- Cooperates with Board of Medical Examiners of the Department of Registration and Education.
- Maintains liaison with hospital associations.
- Offers personal visit of Society President, other officers and staff members at county society meetings, upon request.
- Assists component societies with public relations programs.
- Provides full dues collection service for component societies.
- Offers medical profession's views to state officials and governmental agencies.
- Holds Public Affairs Programs which provide information on candidates for public office.
- Provides news releases to all print and broadcast media—newspapers, magazines, radio, TV—to keep public abreast of medicine's position on important issues and aware of good personal health policies.
- Prepares weekly health news items.
- Works with medical schools and their deans in developing innovative programs of training.
- Has sponsored, with Illinois Agricultural Association, a Student Loan Fund program, for approximately 20 years.
- Has developed ways and means of involving medical students in affairs of Illinois medicine.
- Maintains an Impartial Medical Testimony Panel for Illinois and U.S. Courts.
- Cooperates in many avenues with AMA, in various programs.

- Provides literature and reference material on selected topics to schools and students.
- Furnishes information on internships and residencies.
- Sponsors membership tours to foreign areas at special reduced rates. In 1971 to such places as South Pacific, Mediterranean, Africa and the Orient. Total of 495 doctors and wives participated.

All of the above, and far more too detailed to be included, is accomplished through more than 45 standing Councils and Committees on which hundreds of physicians serve with implementation by a most efficient staff. All members are urged to make known their interests and desires to serve and advise on clinical, scientific, socio-economic, medical-legal and organizational matters.

The above reviewed very briefly the direct and indirect services to the members, an indication of what one obtains for his dues dollar. Mention should also be made of the manner in which such revenue is managed.

In the past a dues increase was adopted in 1965, effective for 1966. Included was a contingency reserve system whereby a set amount was put aside for future use. Over a five year period this allowed for the expected increases in the cost of doing business. In addition, a reserve fund has been established in accordance with sound financial principles and expert advice to have an emergency amount available equal to one year's normal operating expense. These reserve funds are essential insurance to guarantee the maintenance of the services noted above. There has not been a dues increase in seven years and this attests to the prudent judgement exercised by the House of Delegates in establishing such reserves. Good investment and return have been accomplished, which helps to build the fund. There are going to be changes in the delivery of health care, and there obviously may be emphasis on means of controlling quality of care and health care delivery. The Society must be ready to help develop these changes. That will take money, and time. Your Board of Trustees will report further to you about these matters.

Benefits of membership and the kinds of efforts ISMS is undertaking on behalf of the members are startling in their scope. You may be proud to be a member of such a dynamic group.

Acknowledgment and Thanks

Each year I have taken this opportunity to officially acknowledge the excellent cooperative efforts of the ISMS staff and to thank them individually and collectively for their successful completion of new goals and achievements, firm and sincere in the conviction that this has been their "finest year." During 1971, however, this staff has been severely put to the test of their capabilities and endurance. Faced with both unknown-indepth and unexpected projects to be implemented despite increased operational costs and no increase in budget, Mr. Roger N. White guided his staff to meet the challenge. However, he asked of them no more than he was willing to give of himself in long daily hours and lost weekends. While he, as team captain, receives the trophy, the accolades of appreciation from the membership go to each and every staff member, including the newest employee, Miss Amelia Mudd.

It is likewise our hope that they feel that the Illinois State Medical Society is "a good place to be."

Jacob E. Reisch

BENEVOLENCE COMMITTEE

The Benevolence Committee started in 1971 carrying 30 recipients—two physicians and 28 widows of physicians. During the year, three widows were removed from the list—one by death, one by marriage, and one by improved financial condition. However, the year ended with a list of 30 again, as two doctors and one widow were added to the rolls. The monthly average for 1971 was \$5,515 in actual payments.

Investments of the Committee are made by the Trust Department of the Continental Illinois National Bank & Trust Company. Custodial account charges are paid from the general funds of the Society, since monies paid into the Benevolence Fund cannot be paid to other than a recipient, according to the existing Bylaws under which this committee operates.

When the expenses of this committee are studied by the Reference Committee on Finances, Budgets & Publications, the rulings under which the committee functions will be called to its attention.

The Benevolence Committee is grateful to the assistance of the Woman's Auxiliary whose contributions to the fund amount to approximately one-eighth of the total assistance payments. In 1970 the Chicago Medical Society turned over to the fund a substantial bequest it had received and this contribution has been helpful in allowing the committee to increase some of its payments to recipients suffering from the high cost of living.

Keith H. Frankhouser, *Chairman*

Allison L. Burdick

Leo P. A. Sweeney

CONVENTION '72

A record-high number of specialty societies have indicated their desire to participate in Convention '72, representing the combined annual meetings of the Chicago Medical Society and the Illinois State Medical Society, to be held March 7-11 at the Conrad Hilton Hotel.

According to Program Chairman T. Howard Clarke, M.D., the various societies involved are bringing an outstanding panel of medical educators—teachers, researchers and practitioners in various aspects of medicine. Societies which have arranged programs or indicated their willingness to participate in the Conference include:

- Chicago Allergy Society
- Chicago Society of Anesthesiologists
- Illinois Chapter of the American College of Chest Physicians
- Chicago Gynecological Society
- Illinois Obstetrical and Gynecological Society
- Illinois Society of Internal Medicine
- Chicago Laryngological and Otologic Society
- Chicago Orthopedic Society
- Illinois Society of Pathologists
- Chicago Pediatric Society
- Illinois Chapter American Academy of Pediatrics
- Illinois Society of Physical Medicine and Rehabilitation
- Chicago Society of Plastic Surgery
- Illinois Psychiatric Society
- Illinois Chapter of American College of Radiology
- Chicago Surgical Society
- Illinois Surgical Society

The participation of these various societies provides added impetus to the Conference's impact, said Dr. Clarke, adding that the Conference will serve as an excellent forum to many prominent physicians and teachers. He noted that the specialty society activities will be over and above other traditional features of the Conference which have made it a major medical event in the United States. He listed these as the all-day session on trauma arranged by the Chicago Committee on Trauma of the American College of Surgeons, four instructional courses in various aspects of medicine, a complete and comprehensive program of medical films, and a full display of scientific and technical exhibits.

Other sessions of general interest to all physicians are being planned in quality control, the problem oriented medical record, utilization review, and medical socio-economics, he added.

Governmental Affairs

GOVERNMENTAL AFFAIRS COUNCIL

1971 was one of the most successful years in ISMS legislative history. We saw the introduction and enactment of complicated legislation which made it through the hurdles after some tough sledding.

Following is a report of the legislative activities of your Governmental Affairs Council. The report on legislation is divided into four sections—legislation instigated by ISMS, legislation supported by ISMS, legislation we sought to amend, and legislation we opposed.

We had a remarkable legislative year. If nothing else, the track record shows what physicians can achieve by pulling together to achieve a goal. Secondly, the year also proved that health care delivery, indeed, has grasped the imagination of the lawmaker.

ISMS Legislation

Drug Labeling Bills: Governor Richard B. Ogilvie approved three ISMS-instigated bills which require the labels on all prescription items to contain the name of the medicine, dosage and quantity. The bills apply to dispensing physicians as well as pharmacists. The only exception to the requirement exists when the physician specifies in writing that such information be omitted.

School Physical Exams: The topic of legislation introduced to permit exams to be given to children entering kindergarten or first, fifth and ninth grades within a six-month period prior to entering the particular grade level. Too many school superintendents were requiring the exams to be given the month before school started, thus causing an August jam-up in physicians' offices.

Blood and Human Tissue were held to be a product rather than a service by the Illinois Supreme Court in *Cunningham vs. MacNeal Memorial Hospital*, which meant there were implied warranties that the blood was pure. House Bill 16 was introduced to relieve hospitals, physicians, blood banks and potentially the donor from liability when negligence is absent. The bill has been signed by the Governor, but it has an automatic expiration date of July 1, 1973.

Additional legislation granting immunity to physicians when serving on peer review committees has become law, and legislation has been introduced granting legal immunity for their actions to persons serving on H.A.S.P. committees of the Illinois Foundation for Medical Care. The immunity from liability does not exist in cases involving willful or wanton misconduct.

Physical Exams for School Bus Drivers has been a regulation issued by the Superintendent of Public Instruction. Unfortunately, some school districts do not obey the regulation, and ISMS considered submitting mandatory legislation. After consulting with the new Superintendent of Public Instruction, we were assured the regulation would be enforced and did not write the legislation for introduction.

Psychiatrist-Patient Confidentiality was the thrust of legislation which promoted privileged information in the

doctor-patient relationship in civil cases falling within the provisions of the Divorce Act. Previously, there was no privileged communication between patient and psychiatrist when a patient introduced his mental state as an element of his claim or defense in a civil or administrative proceeding. Now there is confidentiality unless the patient introduces the communication as evidence to prove his mental condition.

Medicine's Contribution to easing the manpower shortage crisis in Illinois came with legislation which will permit medical school deans to grant a student advanced standing when the dean has permission of the Department of Registration and Education to do so. This will allow some students to complete medical school sooner.

Legislation Pending in the House Registration and Regulation committee would require a person licensed under the Medical Practice Act to be a graduate of a school accredited by the National Commission on Accreditation and the Office of Education, Department of Health, Education and Welfare. A companion bill would prohibit chiropractors from utilizing X-ray equipment.

ISMS-Supported Legislation

The administration, individual legislators and other professional groups involved themselves in the subject of health care delivery during the past year. A number of bills in this category were introduced, which ISMS supported. The following bills were recommended to the legislature by the administration:

- Legislation empowering the Medical Examining Board to suspend a physician's license (sick doctor statute) and to permit a physician licensed in a state sharing reciprocity with Illinois to practice for up to six months before taking and passing the reciprocity examination. Also, a bill was introduced to indicate that when a person receives a drivers license he impliedly consents to be tested on his ability to operate a motor vehicle.

- Legislation establishing a Drivers License Medical Review Board to assist the Secretary of State in making medical determination as to the fitness of an individual to drive an automobile.

The sick doctor statute, six-month reciprocity, and implied consent passed the legislature and became law. The Drivers License Medical Review Board legislation was withdrawn from consideration for rewriting and will be reintroduced during the Spring session of the General Assembly.

Individual Legislators introduced legislation on their own initiative to attack problems in health care delivery. Among the bills supported by ISMS were bills creating a category of physician's assistant and establishing a certification procedure, requiring testing for sickle-cell anemia, when necessary in the physician's judgement, during school physical and premarital exams, establishing an independent State Comprehensive Health Planning Agency, appropriating \$15 million and reappropriating \$6.5 million to the Chicago Medical School, and permitting physicians to treat minors from 12 years of age and

up for drug abuse without parental consent.

The physician's assistant bill is still in the Senate Welfare Committee, but other aforementioned bills received legislative approval and were signed into law. However, the Governor did veto the \$15 million appropriation to the Chicago Medical School. The \$6.5 million reappropriation remained intact.

Other Professional Organizations had legislative goals which corresponded to those of ISMS. Among them were professional and quasi-governmental groups which joined with governmental commissions to recommend a dramatic change in our drug laws. ISMS supported legislation which, when enacted and signed into law, became the Illinois Controlled Substances Act and the Illinois Cannabis Control Act.

ISMS joined with dozens of other professional organizations to support legislation which would prohibit home rule units from licensing professions already licensed by the State. After failing to see such legislation enacted during the Spring session, ISMS joined the other groups in a major grass-roots lobbying effort over the summer recess. We now have enough committed votes to pass the bill if the sponsor, Sen. William C. Harris, can prevent any crippling amendments from being added.

Finally, ISMS supports legislation which establishes a licensure procedure for opticians. An amendment must be added, however, placing an ophthalmologist on the examining committee.

Opposed by ISMS

In addition to the bills which annually are introduced and which annually are opposed by ISMS, such as legislation permitting chiropractors to conduct school physical exams, several other bills were introduced which ISMS opposed.

Unfortunately, annual sessions have given rise to an over-utilized category on the legislative calendar called "postponed consideration." In the past a bill was passed or defeated, now it is passed or placed on postponed consideration, which is where most of the bills ISMS worked against have come to rest.

The first such bills are perennial. They 1) create an act to license and regulate clinical laboratory directors under the auspices of the Department of Registration and Education (at present they are licensed only by the Department of Public Health), 2) provide that a director of a clinical laboratory registered with the Department of Public Health prior to 1965 may direct other laboratories not to exceed three in number, and 3) provide that medical service plan corporations may enter into agreements with and make payments to independent licensed clinical laboratories not directed by physicians.

The sponsor has tabled the first two bills and is willing to agree to an amendment to the third permitting payment to be made only when the testing is prescribed by the physician. By a split vote your Governmental Affairs Council consented to this amendment. It still must be approved by the Board of Trustees.

The Optometrists were aggressive during the past year in Springfield. They introduced two bills—one to expand the functions performed by optometry and the other to require mandatory vision exams by an ophthalmologist or an optometrist for children entering kindergarten or first, fifth and ninth grades. ISMS opposed both bills. Both passed the House, but the first was killed in Senate committee. The second has yet to be heard in committee.

Also active in the legislative sphere this year were psychologists, who seek to be reimbursed through health insurance programs. Three bills were introduced in the Senate to accomplish this goal. They were assigned to the Senate Welfare Committee and are still resting in that committee. ISMS is willing to discuss an amendment permitting the payments to be made to qualified clinical psychologists if an M.D. first has determined that the disturbance does not have a medical genesis.

Finally—at the direction of the House of Delegates—ISMS opposed legislation which would empower the Director of the Department of Public Health to exercise dictatorial powers in approving the addition of facilities to existing hospitals or the construction of new hospitals.

The bill, H.B. 2653, would prohibit the addition of any new facility or construction of new hospital unless the Director first issued a permit. ISMS objected to the legislation on the grounds that it does not provide satisfactorily for local input into the decision-making.

After the bill failed to pass on third reading it was placed on postponed consideration. The sponsor asked ISMS to participate with proponents of the bill in re-writing the bill to overcome ISMS objections. At present the committee is still working out a compromise proposal.

Amended Legislation

Occasionally legislation is introduced which is not objectionable in principle, but which does have objectionable details. Several such bills have been introduced and either were amended or are in the process of amendment to meet ISMS objections.

Definition of Death: Rep. Bruce Douglas, on behalf of the Institute of Medicine of Chicago, introduced legislation which offered a legal definition of death. The bill was rewritten by the House Judiciary Committee in such a way as to make it unacceptable. At present an ad hoc ISMS committee is working with the bill to make it acceptable to the medical profession.

Another committee working to improve legislation is the Laboratory Services Committee, which is rewriting a bill which prohibits the sale or purchase of blood. The bill, as written, would put almost all Illinois blood banks out of business, but the Laboratory Services Committee intends to devise a workable alternative prior to the reconvening of the General Assembly in April.

The State's Attorneys Association successfully promoted legislation which ISMS could not accept, unless amended. The bill required a physician to report to a local law enforcement official immediately when a person requested treatment for an injury sustained from the discharge of a firearm in the commission of or as a victim of a criminal offense, or as a result of unlawful drug usage.

ISMS objected to the latter provision in that it negated the efforts of another bill supported by organized medicine which would permit physicians to treat minors from 12 years of age and up for drug abuse without notifying the parents. The objectionable provision was eliminated and instead of "immediately" notifying law enforcement officials, a physician must notify them "as soon as treatment permits."

Fee-Splitting was the subject of a very controversial piece of legislation. The law defines fee-splitting as "directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered."

Two amendments were added at ISMS request to exclude fees paid to members of medical corporations or group practices which are then put into a common pool and shared by all participants in the corporation and to permit two or more physicians participating in a single case to share a fee in proportion to the services performed and responsibilities assumed by each.

This new law has raised many questions, and the Department of Registration and Education has agreed to promulgate a list of rules and regulations as a guideline to the physician in his billing practices. As soon as these rules are developed they will be distributed to ISMS members.

House of Delegates Actions

The 1971 House of Delegates adopted resolutions and reports affecting the activities of the Governmental Affairs Division. The most basic was a resolution changing the name of the Council on Legislation and Public Affairs to the Governmental Affairs Council. All necessary administrative changes have been completed.

In addition, the House directed that ISMS oppose substitution of prescribed drugs except in cases of emergency or urgent need, and that a letter be sent to the Illinois Pharmaceutical Association, the Department of Public Health and the Department of Registration and Education over the President's signature. This action has been completed.

Legislative Position: The House of Delegates urged ISMS to seek legislation removing the citizenship requirement to complete the exam for licensure. Adoption of H.B. 1245 satisfied the requirements of this resolution.

In addition, following the directions of a supplemental report of the Council on Legislation and Public Affairs, ISMS membership was informed of our opposition to H.B. 2020 and 2033, which were discussed previously and were promoted by optometry, and our support of H.B. 2113, which called for mandatory eye screening for children entering kindergarten or first, fifth and ninth grades. They were also notified of our opposition to H.B. 2653, the Hospital Licensure Bill, through stories in the "Pulse" and the *IMJ*.

Forensic Medicine: The House recommended adoption of a statewide Medical Examiner system, and preparation of a draft of a new law embodying this resolution for the legislature. As a result, the ad hoc Forensic Medicine committee has been established to draw up such a proposal for consideration by the Governmental Affairs Council.

Resolution 71M-21 requested that ISMS encourage and support legislation requiring the establishment of health departments on a county or multi-county basis, and that these health departments be governed by a board of health with authority to ordain the health tax levy within the limit prescribed by the statutes. The Governmental Affairs Council considers it imperative that the entire county health department statute be studied. The Council requested the Board of Trustees to refer the resolution to the Council on Social and Medical Services for study and recommendation on possible changes in the law.

Liability Legislation: Responding to a resolution addressed to the malpractice problem, ISMS instigated the introduction in the Illinois House of Representatives a House Joint Resolution calling upon the Illinois Bar Association to recommend a means of eliminating non-meritorious malpractice suits. This resolution eventually

will be followed by legislation promulgating the ISMS solution to this problem, which will:

- Establish a statute of limitations of three years after injury in malpractice suits.
- Reduce the statute of limitations from ten to five years after treatment on foreign substances negligently left in the body.
- Prohibit the invoking of the doctrine of *res ipsa loquitur* (the fact speaks for itself) in malpractice suits.
- Require verification of the pleadings (swear to the truth of the allegations) in malpractice cases.
- Require plaintiffs in malpractice cases to post a \$500 surety bond.
- Extend the Good Samaritan concept to any emergency situation on the premises of a hospital.

Public Affairs

Due to the death of Mr. Timothy D. Selleck, the Key-Man Banquet in Springfield was cancelled. Part of the program scheduled for this dinner was the presentation of awards to the five outstanding legislators selected by readers of the *Illinois Political Reporter*. The awards eventually were presented at a special luncheon program at the Leadership Conference.

A special award was presented to George T. Wilkins, M.D., of Granite City, for his activities on behalf of the ISMS legislative program. It was the First Annual Key-Man award presented by the Public Affairs Committee.

The Public Affairs Committee also has been active in preparation for the Public Affairs Dinner to be held Wednesday, March 8, at the ISMS Annual Meeting. In addition, plans already are underway for the "Washington Roundup."

Ear, Nose and Throat

Members of the Ear, Nose and Throat committee have prepared legislation which certifies Illinois hearing aid dealers. The committee has held meetings with members of the Illinois Hearing Aid Dealers Association to formulate a bill which is agreeable to both groups. Licensure legislation contrary to ISMS policy for the dealers was introduced but no effort was made to pass the legislation by the sponsor.

Eye Health

The Eye Health Committee has been concerned with the aggressiveness of optometry at the state legislative level and has become more aware of the legislative process. The committee recommended ISMS support of the following legislation:

- Mandatory vision screening of school children by qualified personnel
- Licensure and regulation of the practice of opticianry
- Physician's Assistant legislation as long as it does not prohibit an ophthalmologist from employing an assistant.

ISMS opposition to legislation which would expand the functions to be performed by optometrists and a provision in the Scott-Percy national health insurance legislation which equates optometry to ophthalmology was encouraged.

During the past year, the Committee also recommended that ISMS join with the Illinois Association of Ophthalmology in filing a brief on behalf of the House of Vision in a legal dispute instigated by the State of Illinois at the prompting of an optometric association.

Forensic Medicine

The Coroner System Study Committee created to eliminate the office of coroner under the provision of the 1970 Constitution recommended that it be discontinued and replaced with an ad hoc Forensic Medicine Committee charged with creating a proposal to establish a medical examiner system in Illinois. The Forensic Medicine committee has established the following four guidelines.

- Establishment of standards for a medical-legal investigative system
- Elimination of the present coroner system
- Set criteria for the office of any system, to include equal balance of all medical and investigative fields
- Proper handling of all types of forensic cases including those not limited to the dead body and including toxicology.

The committee has set a date of March 1, 1972 as its deadline date for final draft of a proposed medical-legal investigative system for the state.

Alfred J. Faber, *Chairman*
John J. Ballenger (E.N.T.) James Laidlow
Edward G. Ference Colman J. O'Neill
Frank Holman John W. Ovitz (Public Affairs)
Warren W. Kreft (Eye Health) Warren Tuttle
James Ryan

C. J. Jannings, III
Frederic D. Lake

Consultants

William M. Lees
Robert Fox

George Shropshire
Mrs. James Kopriva, *Auxiliary Representative*
Mark Brakke, *SAMA*

Ear, Nose and Throat Health Committee

John J. Ballenger, *Chairman*
George H. Conner Richard E. Marcus
Paul H. Holinger Guy O. Pfeiffer
William A. Weiss

Meyer Fox

Consultants

Earl Hartford, Ph.D.
Maurice Hoeltgen

Eye Health Committee

Warren W. Kreft, *Chairman*
Frederick Crowley Elwood Kortemeier
Maurice M. Hoeltgen Samuel Schall
John Helm Alfred G. Schultz
Robb Smith

Ad Hoc Committee on Forensic Medicine

Grant C. Johnson, *Chairman*
Thomas P. DeGraffenried James H. Ryan
Edwin F. Hirsch Martin Swerdlow
Eugene Scherba
Frank Pfeifer, *Consultant*

Committee on Public Affairs

John W. Ovitz, Jr., *Chairman*
Herbert Sohn, *Co-Chairman*
William Ashley John L. Savage
William W. Boswell Julius P. Schweitzer
Herschel L. Browns Lee Winkler
William J. Hillstrom Eugene H. Siegel
James Heersma Lorin D. Whittaker
Rocco Lobraico, Jr. Elliott Patridge
Earl V. Klaren V. P. Siegel
W. Robert Malony James E. Coeur
Charles Downing Justin Fleschmann
James D. Rogers George J. Gertz
Stanley E. Ruzich J. R. Shackelford
James H. Geist Robert Pierce

John Seward

Consultants

Theodore Grevas Frederick E. Weiss
Mrs. H. J. Failor *Auxiliary Representatives* Mrs. Harry Parks
Steven Lipnik, *SAMA*

Annual Illinois State Medical Society President's Banquet

Honoring
L. T. FRUIN, M.D.

Thursday, March 9, Grand Ballroom
Conrad Hilton Hotel

6:00 p.m. Reception

7:00 p.m. Dinner

8:00 p.m. Presentation of Awards

\$15.00 per person

Reservations through ISMS Convention Manager

Medical-Legal

MEDICAL LEGAL COUNCIL

The Medical Legal Council is responsible for maintaining liaison with the Bar Association, and with educating the members in medico-legal affairs.

Within the Council are the Committees on Impartial Medical Testimony, Laboratory Services, and Licensure. Incorporated in this report are the actions of the Council and its constituent units.

We are indebted to many groups, agencies, and individuals for help collecting information. In particular we would like to thank the Illinois Department of Registration and Education and the Administrative Office of the Illinois Courts.

Since the last meeting of the House of Delegates the Council has addressed itself to matters concerning medical liability, the Interprofessional Code and national licensure.

Malpractice Screening Panel: Last year we reported that the Council had met with the Liaison Subcommittee of the Chicago Bar Association in an effort to once again reach an agreement on a plan for a screening panel. Since that time the only communication from the Chicago Bar Association was a brief letter stating that their Medico-Legal Relations Committee was not interested in further discussions regarding formulation of a screening panel.

As a result of this rejection, the Medical Legal Council has met with the Regional Director of the American Arbitration Association to discuss arbitration as a possible means of resolving medical malpractice controversies.

The Council has appointed a subcommittee to meet with representatives of the Illinois Hospital Association to discuss the possibility of a pilot arbitration program in Illinois. Board approval will be requested when the Council is ready to recommend a specific course of action.

Interprofessional Code: Various problems regarding the Interprofessional Code have been brought to the attention of the Council. Problems center primarily around the question of subpoena. The chairman has appointed a subcommittee to study the problem and report.

Response to Resolution 71M-17: Resolution 71M-17 called for support of legislation eliminating contingency fees in malpractice suits and asking that court costs and attorney fees be assigned to the party losing such suits.

The Governmental Affairs Council has instigated the introduction of a House Joint Resolution in the Illinois General Assembly which calls upon the Illinois Bar Association to establish reasonable guidelines for the detection and elimination of non-meritorious medical malpractice lawsuits and the discouragement of contingency fees in such cases. This Council feels that this action, along with a series of proposed bills being prepared by the Governmental Affairs Council, meets the intent and mandate of Resolution 71M-17.

Licensure

During the past year the Committee on Licensure has

been concerned with problems related to licensure and the Department of Registration and Education.

Licensure Legislation: Last year the Committee reported that the Department of Registration and Education was preparing legislation to allow a physician licensed in another state to practice in Illinois on his out of state license for a period of six months. Since the last Annual Meeting, HB 2265 has been passed by the Illinois General Assembly and signed into law.

An additional amendment to the licensure section of the Medical Practice Act eliminated the requirement that an applicant for licensure be a citizen of the United States or be in the process of gaining citizenship.

Close cooperation between the Department and ISMS was necessary to see these bills passed by both houses of the legislature. It appears they will attract more physicians to Illinois.

The Committee also has been concerned with legislation regarding chiropractic licensure in Illinois. HB 2155 would amend the Medical Practice Act by requiring any person first applying for a license to practice medicine in all its branches, or for a license to treat human ailments without drugs or medicines, and operative surgery, to be a graduate of a professional school or college accredited by an accrediting agency approved by the National Commission on Accreditation and the Office of Education of the Department of Health Education and Welfare.

CHP Study of Department of Registration and Education: The purpose of the study was to review the rules, regulations and operating procedures of the Department. There was specific concern with the effect current rules and regulations have on the manpower shortage in Illinois.

The study was not done to affect the Medical Practice Act. Therefore there probably will be little, if any, legislation recommended as a result of the study.

National licensure: The Committee has prepared a resolution urging opposition to the concept of national licensure of physicians and support for the preservation of state boards of examiners. This resolution was submitted by the Illinois Delegation to the AMA and adopted during the Clinical Meeting in New Orleans.

Laboratory Services

The Laboratory Services Committee has devoted its attention to problems related to rubella testing, the Boston Agreement with the American Red Cross, and House Bill 1759 which would prohibit the purchase or sale of human blood or its derivatives.

Rubella Testing: The Committee considered the advisability of routinely checking patients for rubella immunity and concurred with the recommendation of the Child Health Committee that the test for rubella immunity become an essential part of every patient's pre-marital or initial pregnancy work-up.

Resolution 71M-37: As adopted by the House of Delegates, this reaffirmed the Boston Agreement between the AMA and the American Red Cross. In addition, the resolution mandated that the appropriate ISMS Committee inform the Illinois Chapter of the American Red Cross regarding the actions of the House of Delegates and that county societies also be alerted in this regard. The Committee has fulfilled the intent of Resolution 71M-37.

House Bill 1759 (Prohibits sale of blood): The Committee is unanimous in its feeling that HB 1759 be strongly opposed in its present form. The Chairman has called a meeting of Blood Bankers in order to prepare amendments to the bill. As of the writing of this report these are being prepared.

Impartial Medical Testimony

The Committee on Impartial Medical Testimony has been concerned with the activities related to the IMT Panel, Workmen's Compensation, and No-Fault Insurance. **IMT Examinations:** The IMT program continues to provide valuable service to the Illinois and U.S. District Courts. In 1971 IMT panelists were utilized in 48 cases involving 56 examinations. As in years past, the vast majority of the requests have been in Cook County. More than half of the examinations requested have been for orthopedic specialists. The importance of the program should not be confused with the volume of its use.

Workmen's Compensation: The Chairman of the Illinois Industrial Commission, Alexander White, met with the Committee to discuss problems related to the lack of support by Illinois physicians for the Workmen's Compensation Program in Illinois.

Among various possibilities discussed was establishment of a panel similar to the present IMT panel which would handle examinations for the Industrial Commission. The Committee pledged its cooperation in assisting the Industrial Commission and is awaiting further communication.

No-Fault Insurance: The Committee is concerned about the recently passed No-Fault Insurance Bill as it refers

to an "impartial medical panel." Although the Act does not appear to specify how the panel will be selected, and there is no reference to Rule 215 (D), Impartial Medical Experts, there is some question as to how this might affect our ISMS panel. As of this writing, the Committee is awaiting the opinion of legal counsel before recommending any action.

Clinton L. Compere, *Chairman*

Vincent Sarley, M.D. (Impartial Medical Testimony)

James Habegger (Laboratory Services)

Ross Hutchison (Licensure)

George Alvary

David T. Petty

Herman Wing

Leonard C. Arnold

Theodore Balsam
Consultants

Joseph L. Bordenave

William Lees

Frederic Lake

Allan Goslin

William Adams
SAMA Representatives

Gregory Keller

Edward Quebbeman

Committee on Impartial Medical Testimony

Vincent Sarley, *Chairman*

Dennis Dorsey

Jerome J. McCullough

Maurice D. Murfin

Consultants

William Adams

Robert T. Fox

Committee on Laboratory Services

James Habegger, *Chairman*

Ronald Jessen

John J. Mueller

Peter Soto

Hans Willuhn

Jack Williams

Consultants

Frank J. Jirka, Jr.

Charles K. Wells

Joseph L. Bordenave

Committee on Licensure

Ross Hutchison, *Chairman*

Wilson West

Henry Boldt

Raymond B. Murphy

Morgan Meyer

William T. Davin

Earl Klaren

Orren D. Baab

Consultants

Charles K. Wells

Joseph L. Bordenave

Frank J. Jirka, Jr.

ETHICAL RELATIONS COMMITTEE

The Ethical Relations Committee has met once, March 13, 1971, to hear an appeal from a physician member who had been censured by the local county society for unethical conduct. The Committee affirmed the decision of the local county medical society Ethical Relations Committee. The case was subsequently appealed to the Judicial Council of the American Medical Association and at a meeting on September 19 the decision for censure was upheld.

On the basis of actions taken by the Chicago Medical Society one member was expelled from membership and the membership of two others has been suspended pending further disposition of their cases. Your Committee is aware of no further actions.

William M. Lees, *Chairman*

Allan L. Goslin

L. T. Fruin

Fred Z. White

Mental Health and Addiction

COUNCIL ON MENTAL HEALTH AND ADDICTION

Since last reporting to the House of Delegates, the Council on Mental Health and Addiction, as well as its two Committees, met frequently to address a wide spectrum of items in the field of mental health. The Council and both Committees express their appreciation to the many individuals from other agencies for the time and effort expended in meeting with us and providing input.

Approximately a year ago the Council began development of a booklet, to be prepared for the membership of ISMS, which would provide a basic interpretation of the Mental Health Code of Illinois and explain various admission procedures. In addition, it would include a listing of agencies to which a physician may refer a patient in need of psychiatric care. This will be distributed in 1972.

Concern was expressed during the summer regarding psychiatric services at Cook County Hospital. The Council met with the Executive Director of the hospital and reviewed activities which would set up an acute inpatient service, with broad psychiatric consultation. There was a review of the procedures plus review of the proposal for an outpatient mental health clinic. After extensive dialogue, the Council agreed to support the attempts to improve psychiatric services at Cook County Hospital, with the reservation that the number of patient beds as were described could possibly be deemed inadequate. A coordination of community groups and resources would assist County Hospital in meeting the mental health needs of the community; the Illinois Department of Mental Health and the Illinois Department of Public Aid probably could be of assistance.

Reimbursement for services by psychologists: In the current session of the legislature, Senate Bills 971, 972, and 973 were introduced to amend the Insurance Code and Medical Services Act to allow reimbursement for psychologists when the patient's insurance plan covered mental health. Serious discussion of these bills over a period of ten months resulted in solidified opposition to the bills as they were initially introduced. They would allow any registered psychologist to treat mental, emotional and nervous disorders. The primary disagreement with this is that the medical model would not be maintained. Disagreement over this with the Psychological Association resulted in attempts to meet with that group to define the role of each profession in the delivery of health services. As of this writing, the dispute has not been resolved but discussions are continuing. Opposition to the bills has not been withdrawn.

Confidentiality: Under formerly existing law, a civil suit initiated by a psychiatric patient or former patient automatically waived the privilege of confidentiality of communications to a psychiatrist. This led to many difficulties for both patient and psychiatrist. In addition, mental cruelty as grounds for divorce were cited as the

primary "exception" to eliminating patient-psychiatrist confidentiality. The Council on Mental Health with the help of legal counsel recommended repeal of the patient-litigant exception for psychiatrists except for cases of malpractice. The recommendation received wide support from the psychiatric community and the ISMS. A bill introduced in the legislature was enacted into law which accomplished this purpose.

Legislation: During the year over 30 bills relating to the delivery of health services or mental health were cited to the Council. These were all reviewed and the viewpoint of the Council made known to the appropriate parties. Active liaison was maintained with the Illinois Department of Mental Health regarding much of this to indicate our support and desire to cooperate with the state government in the delivery of mental health services.

Comprehensive Mental Health Services Act: During the legislative session a bill to provide state reimbursement to counties of 300,000 population for mental health services was not passed. A new bill was devised and circulated to the Council for its review prior to introduction into the Illinois Senate in 1972.

State Mental Hospital Standards: The Illinois State Medical Society, thru its Council, has indicated a desire to have state mental hospitals meet the same minimum standards as private hospitals furnishing comparable services. Some dispute arose regarding the standards which would be applied. An initial bill introduced in Springfield to accomplish this purpose was defeated. A second bill which was then introduced called for a reporting mechanism by which the State Department of Mental Health would indicate the progress it is making to meet these minimum standards. The Council and the IDMH agreed that this would be a proper course to follow and that the standards which should be applied would be those of the Categorical Council of the Joint Commission on the Accreditation of Hospitals.

Correctional Institutions: The Illinois Department of Corrections requested assistance in developing psychiatric service sections at state correctional institutions. This is a very broad request. As a result, the Council indicated that the Illinois Psychiatric Society would be asked for its development of these plans prior to this being taken up by the Council. This is in progress.

Treatment of Adolescents: Present law states that an adolescent (under age 18) can receive psychotherapy in a clinic or hospital only with the knowledge and consent of his parents or guardian. In the recent past, some experience indicated that teenagers may often seek help on their own. These individuals may not be treated without parental consent. The Council in discussing this agreed that there were several ramifications and appointed a special subcommittee to investigate this matter. It will be reported at a later date.

Medicare and Denial of Benefits: Over an extended period of time, there has been discussion regarding the denial of benefits for medicare patients. This discussion was heard in many ISMS Committees as well as this Council.

The Council invited representatives of third party carriers and the Social Security Administration to discuss this. After extended debate it was agreed that there is a problem. Regulations are provided by the Bureau of Health Insurance to the carriers. The carriers, in addition, receive interpretations to be applied. A patient is covered only while there is need for acute care. When this is no longer applicable, coverage is terminated. In addition, as the costs of care go up, regulations are made more stringent. In the case of psychiatric patients, there must be a reasonable probability of improvement and there must be an active plan of treatment. This all must be documented. The lack of proper reporting seems to be a primary cause of the denial of benefits. The Council is working to formulate detailed models for therapeutic plans which hospitals may then use to document cases. Further, the Council has communicated with the Illinois Hospital Association and the Illinois Psychiatric Society regarding steps which would help remedy the situation.

Alcoholism

The Committee on Alcoholism has continued to study legislative decisions with a view to formulating alcoholism legislation in Illinois. A bill introduced in the last session of the Illinois General Assembly was reviewed and several amendments were recommended. Support of the Committee for the bill was made contingent upon inclusion of the recommendations. If the suggested amendments are included, the bill, known as the Alcoholism and Intoxication Treatment Act, will be supported.

Resolution 71M-12: This resolution of the 1971 House of Delegates called for revision of the Illinois Mental Health Code. It provided for retention of a chronic alcoholic in a hospital unit for from four to six weeks to assure that adequate time is afforded for treatment. Legal counsel agreed that it would be impossible to confine an individual in a hospital without his consent unless he was afforded the opportunity of judicial hearing. This would be an abridgement of the individual's right. In addition, should the individual not desire treatment, the hospitalization would be of little use. Therefore, the Committee on Alcoholism has recommended by resolution in the current session of the House of Delegates that 71M-12 not be adopted.

Narcotics

The active review of activities in the field of drug

abuse, review of legislative items, recommendations to the membership regarding drug abuse, and participation with other interested groups in meeting this serious social problem, briefly summarizes the activities of the Committee on Narcotics.

Some 39 bills were introduced in the legislature dealing with the control of abused substances and marijuana. After thorough review, the Committee consensus agreed with legislation adopted increasing penalties on pushers while lowering penalties for initial possession of drugs, particularly as this relates to marijuana.

Requests were received during the year for review of drug education programs. The Committee offered its assistance to any group in developing programs. There was no endorsement of any particular venture.

The membership was notified regarding new Federal and Illinois Controlled Substances Acts which were enacted to help control illicit traffic in abused drugs. Under this the former class A and B narcotics were re-scheduled. Many medical societies encouraged the elimination of the use of amphetamines. The Narcotics Committee, however, felt that the membership should be encouraged to make judicious use of these pharmaceuticals, since there are specific medical applications. This recommendation was forwarded to the membership through the county medical societies.

Numerous requests were received for speakers and materials on the subject of drug abuse. Community organizations and school systems need support in this vital area. County Medical Societies are encouraged to establish a speakers bureau to furnish information.

Drug Abuse Council: A very definite need exists for coordinated efforts through some agency in the field of drug abuse. After long deliberation by this Committee and representatives of many other agencies, it has been agreed that a State Council on Drug Abuse should be formed. This activity received the sanction of the Board of Trustees, which authorized the co-convening of a mass meeting to get the organization off the ground. An organization charter will be drawn and a mass congress convened early in 1972. This new group will function in a manner similar to other voluntary agencies. It will be a major coordinating resource with the capability of providing expertise. It will provide a bridge between the public and necessary resources. Basic areas of concern will be the following: research, education, community organization, rehabilitation, public information, and fund raising. It will set up and support ongoing mechanisms for the evaluation of existing programs.

The Council on Mental Health and Addiction and its Committees look forward to a year of continuing challenge in this field. The cooperation and support of the entire membership is needed.

Marshall A. Falk, *Chairman*

Nathaniel S. Apter
Milton C. Baumann
Irving Frank
Abraham Gelperin (Alcoholism)
Richard Graff
Walter P. Passman
Joseph H. Skom (Narcotics)
Albert Glass, *Consultant*
Vladimir Urse, *Consultant*
David Shapiro, *SAMA*

Alex Spadoni
W. David Steed
Donovan Wright
Ronald Schlensky
Howard D. Kurland
Robert DeVito
Patrick Ebenhoeh, *Liaison of Illinois Psych. Society*
J. Ernest Breed, *Consultant*
Earl U. Solon, *Consultant*
Richard Jacobs, *SAMA*

Mrs. John Koenig, *Auxiliary Representative*

Committee on Narcotics

Joseph H. Skom, *Chairman*
George Silvest
David Slight
Richard K. Albers

Richard B. Eisenstein
Kermit T. Mehlinger
Harry W. Parks

Mrs. Leslie Lindeen, *Auxiliary Representative*

Committee on Alcoholism

Abraham Gelperin, *Chairman*
John C. Troxel
William H. Wehrmacher
Mark Larsen, *SAMA*

Charles L. Anderson
David Stinson

ILLINOIS DEPARTMENT OF MENTAL HEALTH

An exciting year of challenge and promise. The Department looks forward to greater service to the public and the profession. A record budget for fiscal '72 will allow this accomplishment.

Mentally Ill Children

In fiscal '71 there were about 300 mentally ill children and 450 adolescents at any one time in Department psychiatric facilities. The goal was to return such children to their families, friends, and schools in the community as soon as possible.

Where necessary, the Department supports and uses community resources to continue care and treatment in the home community. This approach is in keeping with the recognition that institutionalization of children often accentuates the effects of the emotional disturbance itself. Two trends were noted: About half the children admitted to Departmental programs were from the Chicago area. However, there was some increase during the year in the percentage of children admitted from downstate Illinois.

The other trend was more striking: At an earlier time, about four adolescent boys were admitted to Department facilities for every one adolescent girl. By the end of the fiscal year, the ratio was about one-to-one.

The Department recognized the importance of children's programs serving mentally ill children by appointment of a top level policy advisor on children's services.

During the year, plans were completed for a 225-bed Children's Village at the Chicago-Read center. Among other developments, the Department hoped that medicaid changes would permit purchase of hospitalization and outpatient services for indigent youngsters in appropriate community facilities. In the meantime, existing programs for children in Department state hospitals and zone centers ranged from those short staffed in antiquated quarters to others in modern facilities adequately staffed by highly trained mental health professionals. In all instances, emphasis on program development kept any program from being purely custodial.

In fiscal 1971, the Illinois Department of Mental Health committed itself to upgrading all its programs for children as rapidly as possible.

Geriatrics

Fiscal Year 1971 turned out to be a turbulent one for

the Geriatric Transfer Program. In February and March, 1971, conditions in Illinois nursing homes were adversely criticized following an investigation by the Better Government Association and the "Chicago Tribune."

The turmoil stimulated a major review of state policies, programs and responsibilities to long-term care facilities. This review has been carried out by an inter-agency task force. The task force has also assumed responsibility for the assignment of necessary steps for implementation to the appropriate state agencies, and is monitoring results.

Basically the goal of the Geriatric Transfer Program remains the same, with slight alterations. As Gov. Ogilvie stated in September, 1969, on the occasion of signing the Copeland Bills into law: "More than 7,000 elderly citizens today live in mental hospitals—not because they are mentally ill, but simply because they have no place else to go."

While the number of resident patients at inpatient facilities has been declining at an accelerated pace, the number of geriatric residents has declined even faster. The proportion of patients age 65 and over has fallen from 27.8 percent at the end of Fiscal Year 1966 to 20.6 percent as of June 30, 1971.

The proportion of admissions has likewise declined—from 12.5 percent in 1966 to 7.4 percent in Fiscal Year 1971, while the proportion of discharges has risen from 7.9 percent of all discharges to 10.3 percent.

By the end of FY '71 the total number of patients 65 years of age or over was reduced to 4,400. The major goal of FY '71 was to continue on the path set in June, 1970, when the standards for long-term care facilities were elevated.

Provisions in the 1970 standards called for phasing out of sub-standard facilities. This effort is being carefully monitored by an advisory council and an inter-agency task force to prevent a recurrence of the experience between 1965 and 1970 in which little effort was made to require all nursing homes to adjust to higher standards.

It is recognized that it is desirable to move elderly patients out of the state mental health facilities, but it is also recognized that such transfer can take place only after medical review teams have an opportunity to examine all patients in mental hospitals and to screen patients eligible for transfer and to review the facilities into

Mentally Ill Adults

In Illinois, more is being done than ever before to treat mentally ill patients between the ages of 21 and 65. Because of changes in programs, the DMH has been

able to concentrate on intensive treatment of adults.

The Department continues to discharge more patients than it admits. In '71 there were 28,646 discharges with 26,864 admissions. Five years ago the number of discharges was almost the same as the number of admissions.

Over the last five years there has been a 37% reduction in the number of patients in DMH facilities. At the same time there has been an increase of 7.2% in employees. It is significant that there has been a decided increase in patient service employees. (24.4%).

These figures show that there has been a marked increase in the patient-employee ratio, almost to a one-to-one ratio.

This new surge, this new hope for mentally ill adults, has been made possible only because of this favorable ratio. In the past the mentally ill often languished in back wards, untreated, simply because there was not enough staff to give them the attention they needed. Now there is staff and there is time and the mentally ill are recovering and leaving our mental hospitals to find new lives in their communities.

The intensive effort being made to place elderly patients who are not mentally ill into the community allows employees who cared for them to work closely with the adult mentally ill. People who once were automatically assigned to mental warehouses are cared for before they reach that stage.

More and better follow-up services are being given so that patients who leave the hospital are not so likely to falter after discharge and return to the hospital.

The area of community involvement—partnership—is of great importance to the care of mentally ill adults. If most patients can be treated in and by their communities, the state mental health agency can then be free to give specialized skills and facilities, to provide backup services and to take care of those cases so difficult that they can only be treated in a highly intensive manner at a state facility.

And so the Department of Mental Health over the past two decades has become dissatisfied with the concept of placing people in institutions as a method of dealing with mental illness. There has been a steady movement toward community mental health programs that attempt to treat people early. The DMH, therefore, has encouraged the establishment and operation of community mental health clinics.

During fiscal '71 the Department provided state Community Services Grants to 70 local mental health clinics for a total amount of \$5,257,659.78. Provisions for the establishment and financing of mental health clinics by referendum have been available to local communities for several years. This year, with DMH encouragement and assistance, eleven new clinics were voted into existence.

In state-assisted community mental health programs, the number of active outpatient cases jumped from 24,000 in January, 1969, to more than 46,000 by the end of the fiscal year '71, an increase of 91%.

Another service to adults, although limited to short-term interim treatment cases, was the purchase of hospitalization services from approved general hospitals with psychiatric units. This year 2,829 cases involving \$1,984,533 were handled, a great increase over last year's 672 cases cared for with \$437,122.

Preventing people in crisis situations from becoming state hospital patients has been an important aim of the Department. An example is the "Mobile Home Intervention Team" in the Department's Subzone 5 at Chicago. The six-member interdisciplinary team visits and treats

patients and families in crisis at their homes. The Tri-County Unit of the Singer Zone Center in Rockford has expanded its in-care services from 30 to 60 beds. Originally designed for short-term hospitalization, the unit also takes longer term cases including most of those patients who formerly would have gone to a distant state hospital. Madden Zone Center in Hines has opened a 28-bed inpatient unit for Chicago Subzone 9's mentally ill inpatients.

Mental Retardation

The program for the mentally retarded in Illinois can be characterized as one which involves the community in the responsibility for caring, rehabilitating and resocializing the mentally retarded. In 1971 programs for the retarded were directed toward this involvement.

As a result, the Department reduced the populations at Lincoln from 3,759 in 1969 to 2,871 in 1971 and 3,850 to 2,920 at Dixon. At the same time, the employee-patient ratio has been improved at these facilities.

Some of these reductions were made possible by establishing mentally retarded units in nine mental hospitals and two zone centers. This move also provided programs closer to the homes and communities of retarded individuals. Use of the individual care grant program provides financial support for retarded individuals placed in private residential facilities. This placement is made when suitable care is not available in a departmental facility. Other individuals have been placed in community-based facilities where they can be closer to home and their communities.

Community programs for the moderately and mildly retarded adults and children also continued in day care centers and community living facilities.

At the Mt. Vernon tuberculosis sanitarium, the Department established, in cooperation with the Department of Public Health, services for 64 nonambulant retarded adults transferred from Lincoln, Murray, and Anna facilities. One result of this concentrated program is that many of the patients are no longer bedfast.

A program began to eliminate the State waiting list of retarded persons who were needing treatment. Those who had an immediate need were admitted while interim care was provided in private facilities for those who didn't have an immediate need.

Also during the year, plans began for constructing seven MR facilities in the Chicago area. Construction began on the first of these facilities, Ludeman Center, and should be completed by July of 1972.

As a result of increases in community involvement, population reductions will again take place at Lincoln and Dixon. Projections reveal that reductions in 1972 should bring combined populations down to 5,000

Alcoholism

If the sale of liquor was a big business in Illinois in fiscal 1971, so was one of its by-products—the treatment of the alcoholic.

Some \$4.8 million dollars was spent by the DMH alcoholism program; and toward the end of the year Governor Richard B. Ogilvie recommended to the legislature that this sum be increased nearly 50 percent, for fiscal 1972. An estimated 40 percent of adult male admissions to state mental health facilities had problems of alcoholism.

The main focus of state-run alcoholism programs was an intensive treatment; and on a shortened period of hospitalization geared to complete rehabilitation.

A new state plan was being developed during the fiscal year for the treatment and prevention of alcoholism throughout Illinois. This comprehensive plan will coordinate all Departmental facilities serving alcoholics with community alcoholism agencies. Another plan—an innovative, pioneering effort—was being prepared for the treatment of alcoholism among State of Illinois employees. Also underway was a complete directory of all state, private and semiprivate facilities in Illinois for the treatment and prevention of alcoholism.

In a cooperative effort, the Department of Mental Health, Department of Public Health, and the Office of the Superintendent of Public Instruction produced a 64-page book, "Teaching About Beverage Alcohol." This teacher's aid, sent to all Illinois schools, contains a wealth of authoritative and scientific material.

Drug Abuse

Rapid expansion is the Illinois Drug Abuse Program's most significant achievement for this year. Initiation of new programs, the recruiting and training of staff, maintenance of quality while greatly increasing quantity and expansion of research efforts have engaged all the resources of IDAP during the year.

As of now the IDAP is made up of 26 diverse facilities serving 2300 patients. Although there is a waiting list of 600, a new system of holding patterns allows the patient to receive methadone medication until more permanent arrangements can be made.

A new service is the Special Treatment Unit which offers aid to addicts with additional problems. Problems of pregnancy are dealt with through meetings, group therapy, information films and exchanges and assistance to and with community agencies. The Unit also assists addicts with medical and psychological disabilities.

The program, once limited to the Chicago area, has expanded to include other communities in the state. Contractual arrangements have been made to establish drug abuse services to clinics in Rockford, Peoria, Springfield and East St. Louis. Rehabilitation for first-time offenders is being provided in conjunction with the State's Attorney's office.

The greatest problem was the slow loss of key personnel. Creative staff originally assembled to construct the program began to be hired away to be involved in new ventures in other parts of the country.

This year saw the publication of a manual titled "Teaching About Drug Abuse." Prepared with several other State of Illinois agencies, the booklet is to be used by teachers in presenting drug abuse information to students.

Research

Scientific research and development in mental health continues in six major DMH laboratories. There are many studies going on, only a few of which are mentioned here.

At Illinois Psychiatric Institute, Chicago, programs are heavily oriented toward the biology of mental illness. A major program concerns the study of biochemical changes in patients suffering severe depression.

Scientists at the Illinois Pediatric Institute are working on studies of developmental defects related to mental retardation. Biochemical studies are looking into tissue changes during development of the brain.

Studies at the Illinois Institute for Juvenile Research are primarily concerned with the social context in mental illness development. One group has received a large grant from the Illinois Law Enforcement Commission to study the characteristics of youth culture in Illinois which relate to behavioral problems that come to the attention of law enforcement agencies.

Research at Elgin State Hospital is going through a transition. A new program is planned to focus on human behavioral pharmacology—that is, behavioral effects of such drugs as tranquilizers and antidepressants.

An important continuing study at Galesburg State Research Hospital is the investigation of the natural occurrence of metabolites which may produce psychotic behavior, in the biological fluids of schizophrenic patients.

The behavior research laboratory at Anna State Hospital has pioneered in behavior modification studies. These have resulted, for example, in a method for toilet training profoundly retarded adults in an average of four days. Some promising new procedures have been developed for dealing with disturbed people who are destructive to others and to themselves.

In the realm of extramural research, the Department awards grants to universities, hospitals and research institutes for specific scientific projects related to mental health problems.

The Department welcomes your interest or questions. Please contact me as you wish.

Albert Glass, M.D., *Director*

PRESIDENTS DINNER

March 9, 1972

Plan to attend

Public Relations and Membership Services

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

During the past year the Council on Public Relations and Membership Services embarked on several programs to improve communications between ISMS and constituent county medical societies, to tell the medical profession's side of the health care story to the public and to serve as the public relations and publicity arms for ISMS officers, councils and committees.

New Medicare Factsheet: A Medicare Factsheet which tells patients what benefits they should—and should not—expect under Medicare was completed. An initial printing of 100,000 copies was ordered for distribution early in 1972. The Factsheets, which emphasize that patients should not blame their physician for denial—or retroactive denial—of Medicare claims, are designed to be inserted in standard billing envelopes used by physicians. They were to be available at cost to ISMS members.

President's Tour: The Council on Public Relations was pleased to assist our President, Dr. L. T. Fruin, of Normal, in his President's Tour stops in more than 15 Illinois cities. Dr. Fruin's forceful message on "The Problems and the Promises of Medicine" appeared in numerous Illinois newspapers, radio and TV stations. Dr. Fruin appeared before both county medical societies and civic clubs.

President's Newspaper Series: Choosing alcoholism, a major health problem in Illinois, as his Community Health Week theme, a four-part newspaper series by our President, Dr. Fruin, was printed in more than 50 daily and weekly newspapers throughout the state. The series elicited favorable comments from several medical and health organizations in the state.

Radio-TV Speaker's Bureau: The ISMS Radio-TV Speaker's Bureau, which had been inactive, was rejuvenated. During the last few months of 1971, the bureau, which places physicians on radio and TV shows, placed 11 physicians on radio programs in the Chicago area, and 13 physicians on TV programs. This is in addition to numerous radio and TV appearances made by Dr. Fruin throughout Illinois.

Promotion of the MECO Program: In cooperation with the Student American Medical Association and the Illinois Hospital Association, a joint promotional campaign for the Medical Education—Community Orientation (MECO) program was developed. MECO, a program under which medical students spend the summer in Illinois hospitals working with local physicians, placed 145 students in 45 downstate hospitals last summer. Many MECO "graduates" elect to continue the practice of community medicine.

Health Education Programs: Dr. SIMS health education programming enjoyed another successful year. A new series of health columns for high school newspapers was completed and used by 421 high school newspapers, a record number. The Dr. SIMS Health Tips for radio

stations were carried by 79 stations, and 37 daily newspapers in Illinois carried the series of daily health tips.

Journalism Awards Program: The Council's annual Journalism Awards Program had a change in format this year. More than 200 entries from Illinois newspapers, radio and TV stations were judged in January. The winners will be honored at a banquet at the Playboy Towers Hotel in May, rather than March, when the ISMS annual meeting will be held.

New Membership Kits: An additional 150 kits for new or prospective members were mailed out to county medical societies during 1971. To date, 371 of the kits have been distributed.

New Directions: The Council also began preliminary study of several new proposals to improve public relations both inside and outside the society. Development of a program to provide county medical societies with up-to-date publicity materials on fast-breaking medical topics will be tried on a trial basis during 1972. The materials will include "summary sheets" and sample news releases on important health legislation or other medical topics "in the news." The Council will also study the possibility of helping provide local medical societies with TV films on medical topics for use by local TV stations.

Medicine and Religion

The Committee is pleased to report its efforts during the past year in strengthening the bonds between clergy and physicians in bringing faith to the healing process.

Annual Meeting Program: A Medicine and Religion Seminar, "Faith and Reason in Healing," enjoyed a good attendance during the annual meeting in May at Arlington Park Towers Hotel. Dr. William B. Walsh, founder and president of Project HOPE, was featured speaker. An afternoon workshop was also held. The meeting also featured a Medicine and Religion Exhibit and presentation of Medicine and Religion Awards to Dr. Leon P. Gardner, medical director of St. Joseph Hospital, Joliet, and the Rev. R. W. Roth, pastor of St. Peter's Evangelical Lutheran Church, Park Forest. The annual meeting program, including an exhibit and presentation of awards, will be repeated at the 1972 annual meeting in March.

Postgraduate Seminar: A Postgraduate Seminar on Medicine and Religion will be held at Loyola University's Stritch School of Medicine on Tuesday, March 7, 1972. The seminar, co-sponsored by ISMS, the AMA and the university, is part of an annual series of Medicine and Religion programs the committee hopes to stage through Illinois medical schools. The audience will include physicians and clergymen with medical and theological students to be invited as guests. The committee

wishes to express its appreciation for the continued support and invaluable assistance of Mr. Arne Larson, Director of the AMA's Medicine and Religion Department.

Insurance

During 1971 a hospital income plan for physicians and their families was inaugurated: with an initial enrollment of 869. Additional enrollment periods will be scheduled according to demand.

The report at year-end is as follows:

1. Total participants to date:	869
2. Total claims pending:	15
3. Total claims paid:	14
4. Total claims denied:	5
5. Total number of claims:	34
6. Total amount paid:	\$8,975

This plan is the sixth ISMS-sponsored insurance program. Others are the Retirement Investment Program, the Tax-Qualified Retirement Program (Keogh Plan), Group Disability, Group Major Medical, and Professional Liability Programs.

The Professional Liability program has demanded more of the Insurance Committee's attention than the other five programs combined. As the number of participants reached 2,500, the number of claims began increasing and the committee was faced with making judgments on whether to recommend that the insurance carrier accept high risk physicians (those whose insurance was cancelled by other companies) into the ISMS Program.

Because of the rapid changes in the malpractice insurance situation and rising costs of the coverage, the committee has tried to keep abreast of developments by frequent contacts with Parker-Aleshire, present administrator of the ISMS Program; and with others in the field. The committee feels a strong obligation to provide the highest quality service at the lowest possible cost to members of the Illinois Medical Society and, in addition to evaluating available programs, plans to inaugurate an educational program to inform ISMS members about what kind of malpractice suits are being filed and, hopefully, be able to give some tips on how to avoid these claims.

It is anticipated that as some pending suits near trial stage, the committee will be called upon to provide the insurance carrier with some sort of expert testimony. Since it usually takes years before a malpractice claim reaches trial, the committee has not yet been called upon for this service.

Charles J. Weigel, *Chairman*

Paul Biedenharn Catherine L. Dobson
Lawrence Knox (Insurance) Lee F. Winkler
Charles W. Pfister (Medicine & Religion) M. Douglas Hursh
Consultants

Paul W. Sunderland Fredric D. Lake
SAMA Representatives

Henry Covelli Roger Rodgers
Mrs. John Ovitz, *Auxiliary Representative*

Committee on Medicine & Religion

Charles W. Pfister, *Chairman*

William B. Rich William H. Whiting
Clement P. Cunningham David J. Kweder

Milton Miller

Consultants

Rev. Harold Kamenz Father John Marren
Rabbi Mordecai Simon Warren Young

Mrs. Sherman C. Arnold, *Auxiliary Representative*
Stefan Mokrohisky, *SAMA*

Committee on Insurance

Lawrence Knox, *Chairman*

Philip D. Boren Martin Compton
Charles B. Clayman Sanford A. Franzblau
A. Everett Joslyn

Consultants

A. Edward Livingston Fred Z. White

Jacob E. Reisch

50-YEAR CLUB

In 1971, the Fifty-Year Club was increased by 87 new members, those having graduated in 1921, bringing the total membership to 550.

A luncheon was held on May 18, 1971, at the Arlington Park Towers, Arlington Heights, during the Annual Meeting of ISMS, and was attended by 124 members and their families.

It was decided by the Board of Trustees that the First Vice President of the Society be the Chairman of the Fifty Year Club, and Dr. George Schropshar presented the plaques and pins to the new members following a well received talk by Dr. T. R. Van Dellen, Editor of *IMJ* and columnist of the "Chicago Tribune."

Staff has prepared the Roster of the Fifty-Year Club for distribution at the 1972 luncheon at the Conrad Hilton Hotel, Chicago.

PHYSICIAN PLACEMENT SERVICE

During the past year, the Physician Placement Service placed 14 physicians in the following towns; Chicago, Wheaton, Chicago Heights, Rolling Meadows, Springfield, Moline, Joliet, Anna, Mt. Vernon, Geneseo, Woodstock, Rochelle.

In general, it is still the small rural community (under 1,000 population) trying to secure a physician where one or more physicians have practiced, but have died, or left due to the decreasing population in their areas. While many communities have offices available, and newly built clinics, most physicians are just not interested in them.

On October 24, 1971, the combined efforts of the Task Force on Physician Shortage and the Physician Placement Service, in conjunction with the Philippine Medical Association in Chicago, conducted a "JOB FAIR" held at the Marriott Motor Inn, Chicago. Over 70 communities and clinics participated in hopes of securing a physician. All of the physicians registered with the placement service were invited as well as the P.M.A. in Chicago. Dr. Kenneth Schnepf, Chairman, Illinois Medical Examining Committee, spoke to an audience of over 400 regarding a recent change in the Illinois law which permits non-citizen physicians to practice in the state, after passing the FLEX examination.

Dr. Bond Bible, Secretary, Council on Rural Health, AMA, spoke to the community representatives before the opening of the Fair discussing the "why's and wherefor's" of securing physicians for a small town or community and offering the help of the AMA in better promotion of towns through brochures and pamphlets.

The meeting was considered a success by all concerned with nation-wide coverage via newspapers, radio and TV. At least six towns secured physicians and more with hopefuls. The full outcome of the meeting may not be known until later this year. Most of the communities have requested that this meeting be held semi-annually in conjunction with the FLEX examinations or completions of residencies for physicians. The doctors have also expressed this same desire.

While the cost of maintaining the Physician Placement Service has increased tremendously, we regret to report that the return on our "investment" has seriously diminished because of the shortage of available family practitioners. We receive annually over 400 applications from physicians. Towns are still writing every month for new physician names and they are offering the physician good housing, facilities and patients, but seem to get no one. We are stumped as to the answer for more physicians for towns in Illinois, but it seems that this is a trend all over the country.

Social and Medical Services

COUNCIL ON SOCIAL & MEDICAL SERVICES

The Council pursued many matters of socio-medical interest during the past year.

Home Health Care: A special Ad Hoc Committee on Home Health Care was dissolved after achieving its objective, stimulating a unification of Illinois agencies which provide home health care services.

Early this year, the Illinois Council of Home Nursing Agencies voted to change its name to the Illinois Council of Home Health Services and to expand its membership to other home health agencies. The appointment of ISMS' first associate member of the group was approved. Dr. Edward W. Cannady, East St. Louis, former ISMS president, accepted the appointment.

Guidelines for Private Medical Care Firms: The Council compiled a set of "Guidelines for Emergency Health Care by Contract" to aid county medical societies and hospital medical staffs in establishing liaison with private firms which provide emergency health care in some Illinois hospitals and community clinics.

The guidelines were intended to assure continued quality care for emergency medical patients through checks on licensing, credentials of physicians employed by such firms, and compliance to minimum standards of care.

JCAH Workshops Scheduled: Newly revised hospital and medical staff accreditation standards will be discussed during two workshops scheduled next April. The workshops, co-sponsored by ISMS and the Illinois Hospital Association and presented by the Joint Commission on Accreditation of Hospitals, will be held April 6 and 7 (Thursday and Friday), at the Ramada Inn in Champaign, and on April 12 and 13 (Wednesday and Thursday), at the LaSalle Hotel in Chicago. The workshops, each a day and a half in length, will focus on accreditation standards which became effective, July 1, 1971. Dr. Julian W. Buser, Belleville, chairman of the Council's Ad Hoc Committee on Hospital Relations, is handling arrangements for ISMS.

Liaison with Public Health Department: The Council established liaison with Dr. Franklin D. Yoder, Director, Illinois Department of Public Health and Dr. Albert W. Snoke, Gov. Ogilvie's Coordinator of Health Services, who requested advice on how patient care can be improved in nursing homes. Several policy statements on the subject were relayed to the state.

The Council hopes to further strengthen ties with the state in the coming year.

Future Activities: Among future activities assigned to the Council for study by the House of Delegates or Board of Trustees are:

- 1) Possible legislation to make establishment of Boards of Health on a county or regional basis mandatory.
- 2) Selection and role of medical staff member on hospital governing body.
- 3) Mechanisms for resolving physician-hospital disputes.

Aging

The Committee on Aging completed several important projects during the past year.

Special Geriatrics Issue: One of the most important tasks was development of a special issue of the *Illinois Medical Journal* devoted to geriatrics. The issue was published in November in conjunction with President Nixon's White House Conference on Aging. More than 600 reprints of the special issue articles have been ordered.

White House Conference: A member of our committee, Dr. Bertram Moss, attended the White House Conference on Aging in Washington from November 28 through December 2, as an official ISMS representative. Information gathered by Dr. Moss during the conference will contribute to future committee deliberations.

Recommendations Approved: The Board of Trustees approved several recommendations initiated by the committee with respect to nursing home care. The recommendations urged:

- 1) County medical societies to establish "Long-Term Care Committees."
- 2) That the state health department upgrade nursing home regulations to require employment of a medical director on a full or part-time basis.
- 3) That the state public aid department should not ignore "the attending physician's professional judgment and written recommendation regarding the level of care needed for a public aid patient . . . unless the question is submitted to adequate peer review and the attending physician is notified."

Film Series Given to State: "The Time of Your Life," a 13-part series of half-hour films on pre-retirement planning was donated by ISMS to the Illinois Department of Public Health Film Library. The films, produced several years ago under a \$50,000 grant from Blue Cross-Blue Shield, should enjoy wide distribution to civic clubs, senior citizens' groups, and others. The Illinois Delegation to the White House Conference on Aging has recommended that more pre-retirement information be made available to Illinois citizens. Formal presentation of the films was made to Gov. Richard B. Ogilvie in November by Mrs. Willard C. Scrivner, East St. Louis, a member of the Illinois Delegation to the White House Conference on Aging and First Vice President of the AMA Auxiliary.

Annual Meeting Program: The committee has developed an annual meeting program focusing on medical problems of the aging population. Entitled "Approaches to Quality Long-Term Care," the one and one-half hour panel discussion will be moderated by Dr. Thomas T. Tourlentes, committee chairman.

Rehabilitation Services

Bill to License Physical Therapy Assistants: A bill in the state legislature which would have licensed physical therapy assistants died in the legislature during the 1971 session. Earlier the Board of Trustees had concurred in a recommendation that ISMS endorse the certification, but not the licensure, of physical therapy assistants. The recommendation was in line with AMA and AHA proposals for a moratorium on licensing of allied health professionals.

Military Physical Therapy Training: A major project of the committee was to investigate the quality of training given at military physical therapy training schools. Many ex-military personnel seek licensing as physical therapists in Illinois. The committee was gratified to learn that the AMA approves educational programs for 15 allied health professions, including occupational and physical therapy. The AMA representative, invited to attend a committee meeting, said its Council on Medical Education could assume responsibility for approving or monitoring of all allied health occupations if asked to do so by a component state medical society. The Committee felt that such a proposal could be made by ISMS, but referred the matter to the ISMS Committee on Allied Health Education which has proper jurisdiction.

Liaison with DVR Committee: Because of overlapping areas of responsibility shared by our committee and the Advisory Committee to the Division of Vocational Re-

habilitation, it was requested that a DVR Committee member be appointed to our committee for liaison purposes.

Thomas R. Harwood, *Chairman*
William A. Hutchison
Kenneth A. Hurst
Joel S. Rosen

L. T. Fruin, *Consultant*
Ned Bartlett, *SAMA*

Committee on Aging

Thomas T. Tourlentes, *Chairman*
James R. Durham
Sherman E. Kaplitz

Bertram B. Moss
Clyde A. Rulison

A. E. Livingston, *Consultant*
Mrs. Mitchell Spellberg, *Auxiliary Representative*

Committee on Nursing

William A. Hutchison, *Chairman*
Jaroslav F. Neskodny
Charles A. McClelland

Ross Schlich
Robert C. Stepto

Dr. Helen Grace, *Consultant*
Mrs. Joyce Taylor, *Consultant*
Mrs. Thomas Glatter, *Auxiliary Representative*

Committee on Rehabilitation Services

Joel S. Rosen, *Chairman*
John E. Finch
Frank B. Kelly, Jr.
Joseph L. Koczur

John G. Meyer
James C. Reid
Arthur A. Rodriguez

Charles K. Wells, *Consultant*
Frank J. Jirka, Jr., *Consultant*

Ad Hoc Committee on Hospital Relations

Julian W. Buser, *Chairman*

Resolutions

Resolution 72M-1

Introduced by: Ross N. Hutchison, for the Medical Legal Council

Subject: National Licensure of Physicians

Referred to: Reference Committee on Education and Manpower

WHEREAS, the Congress of the United States is considering legislation which includes national licensure of physicians; and

WHEREAS, such legislation would place control of physician licensing in the hands of a centralized federal agency; and

WHEREAS, such legislation would impair, diminish or eliminate the jurisdiction of State Boards of Examiners; and

WHEREAS, loss of state control would not be in the best interest of the patient, physician or quality control of medicine, therefore be it

RESOLVED, that the Illinois State Medical Society oppose the concept of national licensure of physicians, and be it further

RESOLVED, that the Illinois State Medical Society support the preservation of State Boards of Examiners, and be it finally

RESOLVED, that the Federation of State Medical Boards of the United States review current methods of licensing, with particular attention to interstate reciprocity, to discover, anticipate and correct deficiencies relative to national physician distribution.

Resolution 72M-2

Introduced by: Lawrence Hirsch for the Committee on Allied Health Education

Subject: Response to Resolution 71M-54 (Certification of Professional Nurse-Midwives)

Referred to: Reference Committee on Education and Manpower

WHEREAS, Resolution 71M-54 urges that the Illinois State Medical Society cause legislation to be initiated in the Illinois General Assembly for the certification of the Professional Nurse-Midwife in the State of Illinois; and

WHEREAS, this resolution has been referred to the Committee on Allied Health Education for its study and recommendation; and

WHEREAS, the Committee has considered all facets of the question of certification of Professional Nurse-Midwives and the ramifications of extending certification through additional legislation; and

WHEREAS, what is needed is an expression of support for new educational programs expanding the role of present allied health personnel rather than additional licensure; and

WHEREAS, the Committee wishes to observe the AMA suggested moratorium on further licensure of paraprofessionals; and

WHEREAS, the Board of Trustees concurs with the recommendation of the Committee on Allied Health Education; therefore be it

RESOLVED, That Resolution 71M-54 be not adopted.

RECOMMENDATION OF THE COMMITTEE ON ALLIED HEALTH

Certification of Professional Nurse-Midwives

The Committee on Allied Health of the Illinois State Medical Society has reviewed the matter of legislation calling for certification of professional nurse-midwifery in the light of Resolution 71M-54, referred through the Council on Education and Manpower by Reference Committee on Education and Community Health.

This has been discussed with Dr. Hartman of Jacksonville, who proposed the resolution, and learned that the matter is now under further consideration by the ISMS Committee on Maternal Welfare.

The Committee reviewed the joint statement on maternity care of the American College of Obstetricians and Gynecologists (January, 1971), as well as a statement of the Illinois Nurses Association on "specialization and advanced maternity nursing" (March, 1970). Further, members of the Committee met with Dr. Lillian Runnerstrom, of the University of Illinois College of Nursing, who is now establishing a program for nurse-midwife training (post-baccalaureate) at the Medical Center.

Our inquiries indicate that nurse-midwives are able to function with medical supervision in Illinois under the extended Nurse Practice Act. They are not able to practice independently. Questions were raised as to whether the nurse-midwife function was sufficiently enabled under the Nurse Practice Act and this obviously needs clarification, but that decision is beyond the scope and responsibility of this Committee. If it is judged to be a problem the Committee believes the obvious remedy lies in extending the Nurse Practice Act rather than expecting certification *per se* to meet that need. Therefore, it is the recommendation of this Committee that the Illinois State Medical Society not support resolution 71M-54.

In making this recommendation, the Committee would like to make clear that it feels that it is desirable that the Illinois State Medical Society support experimentation with progressively amplified roles for nurses in maternal and obstetrical care and support also appropriate modifications in the Nurse Practice Act as new patterns of professional function are identified and proven.

Part of the background for the above recommendation is the present policy of "moratorium on licensure" of new occupations in the field of medical care and health services and the current state of confusion about physician's assistants.

Resolution 72M-3

Introduced by: C. J. Jannings for the Wayne County Medical Society

Subject: Unified Voice of Organized Medicine

Referred to: Reference Committee on Public Relations and Miscellaneous Business

WHEREAS, The traditional voice of organized medicine has been the County Medical Society, the State Medical Society, and the American Medical Association; and

WHEREAS, it is essential and imperative, in these rapidly moving and changing times that the voice of organized medicine continue to be heard; and

WHEREAS, it is both necessary and desirable that this voice be heard clearly by our friends as well as those who oppose our viewpoints; and

WHEREAS, there has been some muting and some dissonance of this voice because of the proliferation of medical organizations each of which speaks to the public and to government in a parochial manner, therefore be it

RESOLVED, that this House of Delegates urge all members of Illinois State Medical Society, regardless of affiliation with other specialty, regional, or special interest medical organization, to avoid confusing the pub-

lic and governmental representatives and weakening the voice of organized medicine by publicly setting forth positions and policies which are in opposition to those positions and policies adopted by local County Medical Societies, the Illinois State Medical Society and the American Medical Association.

Resolution 72M-4

Introduced by: Charles K. Wells, for the Committee on Constitution and Bylaws

Subject: Amendment to Constitution

Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, The articles in the Constitution of the Illinois State Medical Society could be arranged more logically, be it

RESOLVED, That the Constitution be amended so that the:

Present Article VIII, OFFICERS, becomes Article VI and

Present Article VI, BOARD OF TRUSTEES, becomes Article VII,

and

Present Article VII, CONVENTIONS AND MEETINGS, becomes Article VIII.

Resolution 72M-6

Introduced by: Jack L. Gibbs for the Council on Education and Manpower

Subject: Support for innovative programs in medical education

Referred to: Reference Committee on Education and Manpower

WHEREAS, there have been developed several co-curricular programs in medical education for betterment of the training of medical students and a broadening of experiences for the students, including activities such as MECO but not to the exclusion of any other; and

WHEREAS, endorsement of ISMS for these programs has been sought; and

WHEREAS, no existing policy has been applicable to these programs and the Policy Committee requests development of a statement to provide the mechanism for review and endorsement; therefore be it

RESOLVED, That as a matter of policy the Illinois State Medical Society support innovation in development of curricular and co-curricular programs in medical education, upon review of the merit of each individual program, maintaining the firm foundation of the basic sciences.

Resolution 72M-5

Introduced by: Charles K. Wells, M.D., for the Committee on Constitution and Bylaws

Subject: Amendments to Bylaws

Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, The Bylaws of the Illinois State Medical Society have contained certain inconsistencies and duplications that have caused confusion, and

WHEREAS, Amendments to the Bylaws over the years have resulted in a document that is unwieldy and inflexible, now therefore, be it

RESOLVED, That the Bylaws of the Illinois State Medical Society be streamlined by the attached amendments.

BYLAWS

EXISTING

CHAPTER I. MEMBERSHIP

Section 1. *Members.*

- A. *Active Members.* The active members of this Society shall consist of regular members, emeritus members, retired members, provisional members, intern members and residency members. Active members shall enjoy full privileges which include membership in the American Medical Association.
- B. *Special Members.* The special members of this Society shall be distinguished because of their contributions to the science and art of medicine.
- (1) *Distinguished Members.* Distinguished members shall be:
 - a. Physicians of Illinois or other states, or foreign countries who have risen to prominence in the profession; or
 - b. Teachers of medicine or of the sciences allied to medicine, not eligible for active membership; or
 - c. Members of associated arts or sciences who have made significant contributions to medicine.
 - (2) *Election.* Special members may be nominated by any member of the House of Delegates, and may be elected by the House at any annual convention by a two-thirds vote.
 - (3) *Privileges.* Special members shall not be entitled to hold office nor to vote, and shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other Society activities.

Section 2. *Qualifications for Membership.*

- A. Every physician duly licensed and registered in the State of Illinois to practice medicine in all its branches who is a resident of the State of Illinois, a citizen of the United States, who is of good moral character and professional standing, and a member of his component medical society, shall be eligible for regular membership.
- B. Provisional membership shall be available to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this State to practice medicine in all of its branches, and who—with the exception of United States citizenship—possesses all of the qualifications for membership prescribed by these Bylaws. Provisional membership shall terminate one year after the expiration of

PROPOSED

CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-Training members, and Associate members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

- A. *Regular members.* Regular members shall be those physicians licensed to practice medicine in all of its branches who are residents of the State of Illinois, persons of good moral character and professional standing and members of their component society.
- B. *Emeritus members.* Emeritus members are those who have been regular members in good standing for thirty-five years or who have reached, or will have reached the age of seventy before the next fiscal year of the Society, who have made written application to their component society and who have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.
- C. *Retired members.* Retired members shall consist of those members who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members.
- D. *In-Training members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency in any hospital in the State of Illinois approved by the American Medical Association. They must be recommended for membership by two members of this Society who are also members of the hospital staff where the candidate is in training. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.
- E. *Service members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively full-time in their respective service, and thereafter if they have been retired on account of age or physical disability, or after long and honorable service under the provision of an Act of Congress, shall be elected to service membership. Physicians serving as full-time employees at the headquarters of the American Medical Association shall be eligible for service membership following approval and recommendation by their component medical society.
- F. *Associate members.* Associate members are physicians who hold the degree of Doctor of Medicine, who have a limited license to practice in the State of Illinois and are members of their component medical society.
- G. *Distinguished members.* Physicians of Illinois or other states or foreign countries who have risen

EXISTING

the minimum period of time within which such member could have perfected his citizenship. After obtaining full citizenship and prior to the expiration of his provisional membership, such member may be, upon application to his component medical society, transferred to regular membership.

C. The following shall also be eligible if approved and recommended by the component medical society:

(1) Every physician serving as a full time employee at the headquarters of the American Medical Association;

(2) Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively full-time in their respective service, and thereafter, if they have been retired on account of age or physical disability, or after long and honorable service under the provision of an Act of Congress;

D. Physicians otherwise eligible for membership, and licensed in one of the States of the Union, but not licensed in Illinois, and who are not engaged in the active practice of medicine, but otherwise employed in an allied medical activity which does not require licensure, shall be eligible for membership if approved and recommended by the component medical society and approved by the Board of Trustees.

Section 3. *Emeritus Members.* A member to be elected to emeritus membership shall:

currently be in good standing, have been a member in good standing for 35 years, have reached, or will have reached before the next fiscal year, the age of 70 years, and have made written application to and have been recommended by his component society for emeritus status.

Such membership shall become effective January 1 of the year following election. Emeritus members shall have all the rights and privileges of membership without the payment of dues to the component or state society.

Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.

Section 4. *Retired Members.* A member who has been in good standing but who by reason of age or incapacity, has retired from active practice, may upon application to and upon recommendation of his component society, be made a retired member, without payment of dues to the component or state society.

Section 5. *Intern Members.* Any person who is a graduate of a medical school, who is of good moral character and professional standing and

PROPOSED

to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

Section 2. *Discrimination of membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion or ethnic origin.

Section 3. *Tenure and Termination.*

A. *Tenure of membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

B. *Termination of membership.* Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of this society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Non-payment of dues by May 1 of each year is grounds for termination of membership.

CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. *Dues.* Annual assessments may be levied by the House of Delegates on each component society on a proportional basis. The amount of dues shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price. Only regular in training and associate members will be assessed annual dues. The dues shall be paid by the component society for its members prior to May 1 of each year.

Section 2. *Reduction and remission of dues.* The Board of Trustees upon recommendation of the component society, shall give fifty percent reduction in dues to teaching, research and administrative personnel in full-time employment in the approved medical schools in Illinois, or in similar not-for-profit institutions in Illinois. Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, retired members, and distinguished members are not required to pay dues.

Section 3. *Assessments and Funds.* In addition to dues,

EXISTING

serving an internship in any hospital in the State of Illinois approved by the American Medical Association, is eligible for intern membership upon the recommendation of any two members of this Society who are also members of his hospital staff.

The physician's intern membership shall cease at the end of the year in which his internship training terminates, and if he wishes to become a member of this Society, he must apply for a residency or regular membership through his component society.

Dues for intern membership shall be minimal. Section 6. *Residency Members.* After being licensed to practice medicine, a physician serving full time as a resident in a residency approved by the American Medical Association, is eligible for full membership.

Dues for residency members shall be minimal.

A residency member must be a graduate of a medical school, have a degree of Doctor of Medicine or its equivalent, and must be a member in good standing of his component society.

The physician's residency membership shall cease at the end of the year in which his residency training terminates, and if he wishes to become a member of this Society, he must apply for regular membership through his component society.

Section 7. *Tenure of Membership.* The name of a physician on the properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this Society, and afford all the rights and privileges pertaining thereto.

Section 8. *Withdrawal of Privileges.* No person who is under sentence of suspension or expulsion from a component society, shall be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of the proceedings until he has been reinstated.

Section 9. *Student Committee Membership.* Students nominated by Illinois Chapters of the Student American Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees, to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with permission of the House of Delegates) the right to speak on the floor of the House, but shall have no vote out of committee. They shall pay no dues.

NOTE: Revised Chapter I seeks to clarify categories of membership by dropping the classifications "active" and "special". It describes seven classes of membership, including a new classification to cover interns and residents. All reference to dues has been separated from this chapter and is included in a new Chapter II. Also eliminated from Chapter I is any reference to U.S. citizenship, which is the

PROPOSED

assessments may be made on dues-paying members on recommendation of the Board of Trustees and approval of the House of Delegates. Funds may be raised from publications of the Society and any other manner approved by the Board of Trustees. Funds may be appropriated by the Board of Trustees to be spent on the Society to carry on its publications, to encourage scientific investigations, and for other purposes approved by the Board of Trustees.

CHAPTER III. EDUCATIONAL AND SCIENTIFIC PROGRAMS

Section 1. *Educational and scientific Programs.* Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-Elect 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, and 7) Trustees. Non-voting members of the House of Delegates shall be the past trustees, past presidents, past speakers, general officers of the American Medical Association, and delegates and alternate delegates from the Illinois State Medical Society to the American Medical Association.

Section 2. *Delegates.* Each component society shall be entitled to send to the House of Delegates each year, one delegate for each seventy-five members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws, shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January First following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* The combined Illinois chapters of the Student American Medical Association shall be considered a single affiliate group. The Student American Medical Association, as an affiliate group, shall be entitled to one delegate and one alternate delegate to serve in the House of Delegates with vote. Each delegate shall be considered as an Affiliated Group Member of the Illinois State Medical Society. The term of office shall begin January first following his election and shall be for two years, or until his successor is elected.

Section 4. *Time and Place of Meeting.* The House of Delegates shall meet annually at such time and place as it shall determine.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before

EXISTING

province of the Department of Registration and Education, and the section on student committee membership, which has been moved to Chapter IX, Committees.

CHAPTER VIII. DUES AND EXPENSES

Section 1. *Annual Dues.* Assessments may be levied by the House of Delegates on each component society on a proportional basis. The amount of the dues shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association.

These annual dues shall include the annual subscription to the Illinois Medical Journal which shall be at least fifty per cent of the regular subscription price of the Journal.

Section 2. The Board of Trustees upon recommendation of the component society, shall give 50% reduction in dues to teaching, research and administrative personnel in full time employment in the approved medical schools in Illinois, or similar not-for-profit institutions in Illinois.

Section 3. Physicians in private practice of medicine may be given a 50% reduction in dues during the first year of practice upon recommendation of their component society.

Section 4. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year.

Section 5. The Board of Trustees may authorize the remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association.

NOTE: The revised Chapter II retains all of the provisions and language of the existing Chapter VIII on dues and expenses, but is expanded to include those references to dues which were eliminated from Chapter I.

CHAPTER II. ANNUAL CONVENTIONS

Section 1. *Date.* The Board of Trustees shall determine the date for the annual convention.

Section 2. *Meeting Place.* The meeting place for the annual convention shall be determined by the House of Delegates from a list of cities extending invitations, subject to investigation of the facilities and recommendation by the Board of Trustees.

Section 3. *Scientific Meetings.*

A. With the consent of the House of Delegates or the Board of Trustees any special group may conduct its meeting in connection with the annual convention of this Society.

B. All registered members may attend and participate in the proceedings and discussions of the general scientific meetings and of the section meetings.

C. The general scientific meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and to the public.

PROPOSED

the special meeting is held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the president and/or the secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates will be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Roberts Rules of Order (Revised) shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and other Business.* Resolutions to be printed in the handbook must be submitted nine weeks prior to the annual meeting. Resolutions to be mailed to the delegates prior to the annual meeting must be submitted to ISMS headquarters four weeks prior to the annual meeting. Resolutions submitted after the above date must be approved by the Speaker, Vice Speaker and one delegate from CMS and outside CMS or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Reports of committees, councils and officers requiring action must submit recommendations to the House as a resolution for action. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

EXISTING

- D. All papers read before the Society or any section thereof, shall become the property of the Society. Each paper shall be deposited with the secretary when read, and presentation of a paper to the Illinois State Medical Society shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published.
- E. The Board of Trustees shall be entirely responsible for the annual convention.

NOTE: The revised Chapter III replaces Chapter II, which provides for annual scientific meetings. The revised chapter is proposed for more flexible programming.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of:

- A. Delegates elected by the component societies
- B. The president
- C. The president-elect
- D. The secretary-treasurer
- E. The speaker of the House (or the vice speaker when presiding) and
- F. The trustees.

Non-voting members shall be the vice presidents, the vice speaker (when not presiding), the past trustees, past speakers, past presidents, general officers of the AMA and delegates from the Illinois State Medical Society to the AMA.

Section 2. *Meetings.* The House of Delegates shall meet at the time and place of the annual convention of the Society, and shall fix its hours of meeting so that they shall not conflict with the general scientific meetings of the Society. If the interests of the Society and the profession require, the House of Delegates may meet in advance of the general scientific meetings.

Section 3. *Quorum.* Fifty delegates representing not less than twenty component societies shall constitute a quorum for the transaction of business.

Section 4. *Special Meetings.* Special meetings of the House of Delegates may be called by the president or a majority of the Board of Trustees, or shall be called on petition of twenty component societies.

When a special meeting is thus called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 5. *Delegates.*

A. Component Societies. Each component society shall be entitled to send to the House of Delegates each year, one delegate for each 75 members, and one for a major fraction thereof; but each component society which has made its annual report and paid its assessment as provided

EXISTING

for in this Constitution and Bylaws, shall be entitled to one delegate.

The number of delegates to which any component society is entitled shall be determined by the number of active members of the component society on the membership rolls of the Illinois State Medical Society as of December 31 of the preceding year.

The term of office of a delegate shall begin January 1 following his election, and shall be for two years, or until his successor has been elected. Component societies with one delegate only, may elect for one year.

B. Affiliated Groups. The combined Illinois chapters of the Student American Medical Association shall be considered a single affiliate group.

1. *Representation.* The Student American Medical Association, as an affiliate group, shall be entitled to one delegate and one alternate delegate to serve in the House of Delegates with vote.

2. *Term of office.* The term of office of a delegate shall begin January 1, following his election, and shall be for two years, or until his successor has been elected.

Section 6. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the president and/or the secretary of the component society, stating that the delegate or alternate has been regularly elected to the House of Delegates.

A delegate or his alternate may be seated without credentials, provided he is properly identified and so certified to the secretary of the Illinois State Medical Society.

Whenever a delegate or his alternate are both unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate.

A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by that Committee. After the alternate has been seated, he cannot be replaced for that session.

Section 7. *AMA Delegates and Alternate Delegates.* The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 8. *District Divisions.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

NOTE: The proposed Chapter IV retains most of the provisions of the existing Chapter III, except that in Section 1, the Vice Presidents and the Vice Speaker are given the right to vote in the House of Delegates; the section on AMA delegates and alternates has been shifted to Chapter V, Election of Officers, and the section on Committees has been eliminated. New sections on order of Procedure, Privilege of the Floor, and Introduction of Resolutions have been added to this Chapter.

NOTE: No content changes proposed for Chapters on Election of Officers (new Chapter V) Duties of Officers (new Chapter VI) Board of Trustees (new Chapter VII) and District Committees (new Chapter VIII). Only the numeration is changed.

CHAPTER IV. ELECTION OF OFFICERS
CHAPTER V. DUTIES OF OFFICERS
CHAPTER VI. THE BOARD OF TRUSTEES
CHAPTER VII. DISTRICT COMMITTEES

EXISTING

CHAPTER IX. COMMITTEES

Part 1. COUNCILS AND COMMITTEES

Section 1. *Councils and Committees*

The councils and committees of the Illinois State Medical Society shall be:

- A. Councils (Standing committees)
- B. Reference committees of the House of Delegates
- C. Board of Trustees committees

Section 2. The appointing authority may alter council and/or committee membership and assign or delete duties as it deems necessary.

Part 2. COUNCILS

Section 1. The Councils of the Society shall be:

- A. Medical-Legal Council
- B. Council on Governmental Affairs
- C. Council on Education and Manpower
- D. Council on Economics and Peer Review
- E. Council on Environmental and Community Health
- F. Council on Public Relations and Membership Services
- G. Council on Mental Health and Addiction
- H. Council on Social and Medical Services; and such other Councils as may be established from time to time by the Board of Trustees.

Section 2. *Organization of Councils.*

- A. Councils shall be appointed by the Board of Trustees.
- B. The chairman of a Council shall be designated by the Board. He may not serve as chairman of any committee of the Council.
- C. Each Council shall have authority to request the Board of Trustees to appoint sub-committees for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of the sub-committee.
- D. Only active members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one

CHAPTER V. ELECTION OF OFFICERS
CHAPTER VI. DUTIES OF OFFICERS
CHAPTER VII. THE BOARD OF TRUSTEES
CHAPTER VIII. DISTRICT COMMITTEES

PROPOSED

CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society is as follows:

- A. Councils (standing committees)
- B. House of Delegates Committees
- C. Board of Trustees Committees
- D. Ethical Relations Committee (Chapter 11 of these Bylaws)

Section 2. *Councils.*

A. The *Medical-Legal Council* shall be concerned in the areas of:

- 1. Liaison with the Illinois Bar Association
- 2. Liaison with courts, particularly where impartial medical testimony is involved.
- 3. Implementation of the Impartial Medical Testimony Rule
- 4. Legal aspects of medical practice other than in the area of mental health
- 5. Licensing and standards of practice.
- 6. Quackery
- 7. Anatomical gifts and organ transplants

B. The *Council on Governmental Affairs* shall be concerned in the areas of:

- 1. Federal and state legislation—analysis and communication
- 2. Legislative liaison—both state and federal
- 3. Political education

C. The *Council on Education and Manpower* shall be concerned in the areas of:

- 1. Liaison with medical schools, curricula, etc.
- 2. Health manpower and training
- 3. Postgraduate education
- 4. Internships, residencies, etc.
- 5. Scientific assembly
- 6. Student loans
- 7. Liaison with Student American Medical Association
- 8. Continuing Medical Education

D. The *Council on Economics and Peer Review* shall be concerned in the areas of:

- 1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
- 2. Relations with prepayment, insurance and other third party plans.
- 3. Fees and fee adjudication as promulgated by the Usual and Customary Fee Committee
- 4. Health care cost and utilization
- 5. Peer Review (Part 2 of Chapter XII of these Bylaws)

E. The *Council on Environmental and Community Health* shall be concerned in the areas of:

- 1. Governmental administrative regulation—Departments of Health
- 2. Public Safety
- 3. Occupational Health
- 4. Child and School Health

EXISTING

who currently serves on the same committee of a component society or district.

- E. Each Council, sub-committee or special committee shall have authority to make rules to govern its procedures subject to:

(1) Specific requirements of the Constitution and Bylaws and the policies of the House of Delegates, and

(2) Approval of the Board of Trustees.

- F. Each Council shall submit for adoption, a budget for the ensuing year, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

- G. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

- H. Each Council shall have members in sufficient quantity so that each sub-committee may be chaired by a different member.

- I. Terms of office of members of the Councils shall not be more than three years, but may be terminated at any time at the discretion of the Board. No member of a Council shall serve more than three consecutive terms. Service of two or more years in an unexpired term shall be considered a full term.

J. *Reports.*

- (1) Special committee reports shall be made by the chairman to the sub-committee from which he was appointed.
- (2) Reports from sub-committees (which shall contain summaries of the report of special committees) shall be made by the chairman to the Council of which he is a member.
- (3) Reports of Council activities shall include recommendations on reports and requests from sub-committees, and shall be made to the Board of Trustees by the chairman of the Council.
- (4) The Chairman of the Council with the approval of the Board, may permit any member of a committee under the Council to clarify the report of that committee to the Board.
- (5) The Chairman of any committee may request the Board of Trustees to allow him, or any member of his committee, to appear before the Board.
- (6) All councils shall submit to the House of Delegates, written reports summarizing all actions, and may include recommendations for House consideration.

- K. Vacancies on any committee may be filled at any time by the Board of Trustees. Com-

PROPOSED

5. Pollution

6. Nutrition

- F. The *Council on Public Relations and Membership Services* shall be concerned in the areas of:

1. Publicity and promotion
2. News media relations
3. Exhibits and public service programming
4. Religion and medicine
5. Illinois State Medical Society sponsored membership insurance programs
6. New member orientation and membership benefit explanation
7. Fifty Year Club

- G. The *Council on Mental Health and Addiction* shall be concerned in the areas of:

1. Facilities and services
2. Liaison with Department of Mental Health
3. Legal aspects of commitment, etc.
4. Narcotics and dangerous drugs
5. Alcoholism

- H. The *Council on Social and Medical Services* shall be concerned in the areas of:

1. Health care facilities and services
2. Emergency and disaster care
3. Liaison with other health professional and health oriented organizations
4. Relations with specialists not otherwise assigned
5. Problems of aging
6. Rural Health

Section 3. *Organization of Councils*

- A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.
- B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council. All Committees functioning under the Councils as of January 1, 1972, shall file a final report and be dissolved not later than June 30, 1972.
- C. Members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by Illinois Chapters of the Student American Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with the permission of the House of Delegates) the right to speak on the floor of the House, but to have no vote out of committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any

EXISTING

mittee membership may be enlarged or decreased or the committee may be discharged by the Board of Trustees.

L. *Committee Meetings*

The chairman of a committee, when he considers it expedient and with the consent of two thirds of the members of the committee, may conduct business or hold meetings by mail or by conference call, provided all members of the committee are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all committee members.

Section 3. *Duties (Area of Concern)*

A. The Medical-Legal Council shall be concerned in the areas of:

1. Liaison with the Illinois Bar Association
2. Liaison with courts, particularly where improper medical testimony is involved
3. Implementation of the Impartial Medical Testimony Rule
4. Legal aspects of medical practice other than in the area of mental health
5. Licensing and standards of practice
6. Quackery
7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in areas of:

1. Federal and state legislation—analysis and communication
2. Legislative liaison—both state and federal
3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:

1. Liaison with medical schools, curricula, etc.
2. Health manpower and training
3. Postgraduate education
4. Internships, residencies, etc.
5. Scientific assembly
6. Student loans
7. Liaison with Student American Medical Association
8. Continuing Medical Education

D. The Council on Economics and Peer Review shall be concerned in the areas of:

1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
2. Relations with prepayment, insurance and other third party plans
3. Fees and fee adjudication as promulgated by the Usual and Customary Fee Committee
4. Health care cost and utilization
5. Peer Review

E. Council on Environmental and Community Health shall be concerned in the areas of:

1. Governmental administrative regulation
—Departments of Health

PROPOSED

member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriate action for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

F. Terms of office of members of the Councils shall not be more than three years, but may be terminated at any time at the discretion of the Board. No member of a Council shall serve more than three consecutive terms. Service of two or more years in an unexpired term shall be considered a full term.

G. Vacancies on any Council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of Councils may also be enlarged or decreased by the Board of Trustees.

H. The Chairman of a Council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the Council, may conduct business or hold meetings by mail or by conference call, provided all members of the Council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the Council under which they are operating.

Reports of Council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the Council.

The Chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All Councils shall submit to the House of Delegates, written reports summarizing all actions. Requests for House action or recommendations affecting Medical Society Policy must be submitted to the House in resolution form.

Section 4. *House of Delegates Committees of the Illinois State Medical Society* shall be as follows:

A. *Committee on Credentials* shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. *Committee on Rules and Order of Business* shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

C. *Committee on Tellers and Sergeants-at-Arms* shall

1. Serve the speaker of the House of Delegates
2. Distribute, collect and tally votes when a ballot is taken, or a numerical tally is required.
3. Certify those in attendance in closed or executive

EXISTING

2. Public Safety
 3. Occupational Health
 4. Child and School Health
 5. Pollution
 6. Nutrition
- F. Council on Public Relations and Membership Services shall be concerned in the areas of:
1. Publicity and promotion
 2. Media relations
 3. Exhibits and public service programming
 4. Religion and medicine
 5. Illinois State Medical Society sponsored membership insurance programs
 6. New member orientation and membership benefit explanation
 7. Fifty Year Club
- G. Council on Mental Health and Addiction shall be concerned in the areas of:
1. Facilities and services
 2. Liaison with Department of Mental Health
 3. Legal aspects of commitment, etc.
 4. Narcotics and dangerous drugs
 5. Alcoholism
- H. Council on Social and Medical Services shall be concerned in the areas of:
1. Health care facilities and services
 2. Emergency and disaster care
 3. Liaison with other health professional and health oriented organizations
 4. Relations with specialists not otherwise assigned
 5. Problems of aging
 6. Rural Health

PART 3. HOUSE OF DELEGATES COMMITTEES.

SECTION 1. *Committees*

- A. *Appointment.* Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

- B. *Duties of Reference Committees.* References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

- C. *Organization.* Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if neces-

PROPOSED

sions of the House of Delegates.

- D. *Committee on Changes in the Constitution and Bylaws* shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

- E. *Ad hoc committees* may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

- F. *Such other reference committees* as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *Organization of House of Delegates Committees.*

- A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

- B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

- C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 6. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

- A. The *Executive Committee* shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board, provided he is still a Trustee.

The Board of Trustees may delegate to the executive committee any authority which it possesses and may authorize it to act in any given situation. In

EXISTING

sary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

D. *Reference Committees.* The following committees are hereby provided for:

A Committee on Credentials

A Committee on Rules and Order of Business

Tellers and Sergeants-at-Arms

A Committee on Changes in the Constitution and Bylaws

and such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economics activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

E. *The Committee on Credentials* shall consider all questions regarding the registration and the credentials of the delegates. It shall pass out and receive the attendance slips for each session of the House of Delegates, and perform any other duties assigned.

F. *A Committee on Rules and Order of Business* shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

G. *The Tellers and Sergeants-at-Arms* shall

1. Serve the speaker of the House of Delegates
2. Distribute, collect and tally votes when a ballot is taken, or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

H. *The Committee on Changes in Constitution and Bylaws* shall consider all proposed amendments to the Constitution and Bylaws.

The chairman of the Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

NOTE: The proposed revision of Chapter IX seeks to simplify the Society's organization by strengthening its existing eight Councils and eliminating by June 30, 1972, all committees that have been functioning under these Councils. Sections on House of Delegates committees and Board of Trustee's committees have been re-arranged for clarity but no major changes made.

PROPOSED

all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. *The Finance and Medical Benevolence Committee* shall consist of the Secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommended the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

S. *The Policy Committee* shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. *The Ethical Relations Committee* shall be constituted and function as stipulated in Chapter XI, Discipline, Part 2, Illinois State Medical Society procedures.

E. *The Committee on Committees* shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board. The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

F. *The Committee on Constitution and Bylaws* shall consist of five members of the Board appointed by the chairman and it shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

G. *The Committee on Publications* shall be composed

EXISTING

Section I. *Ad hoc Committees*

1. Ad hoc committees shall be appointed by the speaker of the House of Delegates to accomplish specific duties.
2. Any member of the Society may be asked to serve.
3. The terms of appointment shall be for the duration of the task, or until the committee shall be discharged.
4. Ad hoc committees expected to serve for more than one year, shall be reorganized and given the status of a sub-committee or special committee under the appropriate Council and should be appointed by the Board of Trustees.
5. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees keeping it informed of all current activities.

PART 4. *Committees*

Section 1. Board of Trustees Committees.

The Board shall form the following committees within itself:

- A. Executive Committee
- B. Finance Committee
- C. Policy Committee
- D. Ethical Relations Committee
- E. Committee on Committees
- F. Committee on Constitution and Bylaws
- G. Committee on Publications
- H. Advisory Committee to the Woman's Auxiliary, and

such others as deemed necessary.

Section 2. *Duties of the Committees.*

A. *Executive Committee.* The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board, provided he is still a Trustee.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. *Finance Committee.* The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions

PROPOSED

of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

H. The *Advisory Committee to the Woman's Auxiliary* shall consist of the president elect as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

I. The *Board of Trustees* may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board. All ad hoc committees functioning under the Board of Trustees as of January 1, 1972, shall file a final report and be dissolved not later than June 30, 1972.

Section 7. The *Board of Trustees* shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 8. The term of the members of the *Board of Trustees Committees* shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

Note: No changes proposed for Chapters X through XIV (Except for deletion of *Section 2, Chapter XIII*, which refers to Roberts Rules of Order and which is covered elsewhere in the proposed revision.)

EXISTING

of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Medical Benevolence Committee shall be a subcommittee of the Finance Committee. It shall:

1. Examine applications to the Society for assistance to determine eligibility for assistance.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Recommend to the Finance Committee the allotment for each recipient, and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. *Policy Committee.* The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. *The Ethical Relations Committee.* The Ethical Relations Committee shall be constituted and function as stipulated in CHAPTER XI. DISCIPLINE, Part 2 Illinois State Medical Society procedures.

E. *The Committee on Committees.* The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board. The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

F. *The Committee on Constitution and Bylaws.*

EXISTING

The Committee on Constitution and Bylaws shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

G. *The Committee on Publications.* The Committee on Publications shall be composed of members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

H. *Advisory Committee to the Woman's Auxiliary.* The Advisory Committee to the Woman's Auxiliary shall consist of the president elect as chairman, the president and the chairman of the Board of Trustees.

The Committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

Calls Will Reach You Easily at Convention '72

Doctor, please inform your staff that while you are attending the ISMS Convention, you may be reached through the Physician's Message Center from 9 a.m. to 5 p.m. Tuesday, Wednesday, Thursday and Friday. The number is:

312-341-0064

This is a direct connection which will not go through the hotel switchboard.

Resolution 72M-7

Introduced by: Herman Wing for the Medical Legal Council

Subject: Response to Resolution 71M-17

Referred to: Reference Committee on Governmental Affairs, Medical-Legal

WHEREAS, Resolution 71M-17 called for support of legislation eliminating contingency fees in malpractice suits and that court costs and attorney fees be assigned the party losing such suits; and

WHEREAS, this was referred to the Medical Legal Council; and

WHEREAS, legislation to eliminate the contingency fee has not been introduced; and

WHEREAS, the Governmental Affairs Council has instigated the introduction of a House Joint Resolution in the Illinois General Assembly which calls upon the Illinois Bar Association to establish reasonable guidelines for the detection and elimination of non-meritorious medical malpractice lawsuits and the discouragement of contingency fees in such cases; and

WHEREAS, there is in development by the Governmental Affairs Council a series of proposed bills to make more equitable the climate in which malpractice suits are filed, which bills will be introduced at the most propitious time; and

WHEREAS, this activity meets the intent and mandate of 71M-17; therefore be it

RESOLVED, That since current on-going activity of the Governmental Affairs Council accomplished the intent of Resolution 71M-17 and further action is contemplated, 71M-17 be filed and further noted to the Governmental Affairs Council as the intent of the House of Delegates.

Resolution 72M-8

Introduced by: Walter P. Plassman for the Committee on Alcoholism

Subject: Action on Resolution 71M-12 Hospitalization of Alcoholics

Referred to: Reference Committee on Environment, Community and Mental Health

WHEREAS, Resolution 71M-12 urges that after three admissions for chronic alcoholism, a patient be retained in the hospital mental health unit, upon recommendation of professional staff, from four to six weeks; and

WHEREAS, this resolution has been referred to the Committee on Alcoholism for its study and recommendation, and

WHEREAS, Legal Counsel has advised that Resolution 71M-12 calls for an abridgement of individual rights; and

WHEREAS, the mandatory requirements for hospitalization of alcoholics would not adequately meet the need of the individual patient with no choice in method of treatment; therefore be it

RESOLVED, That Resolution 71M-12 be not adopted.

Resolution 72M-9

Introduced by: James P. Campbell for the Committee on Public Safety

Subject: Response to Resolution 71M-32 Requirements for Ambulance Services

Referred to: Reference Committee on Environment, Community and Mental Health

WHEREAS, Resolution 71M-32 urges that existing

ambulance services not be required to meet the minimum federal standards for such service and be allowed to continue operation; and

WHEREAS, this resolution has been referred to the Public Safety Committee for its study and recommendation; and

WHEREAS, the Committee feels this would encourage a double standard of care and might allow clandestine operations to be established; and

WHEREAS, the Committee is aware of the statewide trauma network being established, which will meet minimum standards of care and will provide for complementary private ambulance service within its operation, which services will meet minimum standards; therefore be it

RESOLVED, That Resolution 71M-32 be not adopted and that ISMS affirm a desire to have all ambulance services meet minimum standards as soon as the statewide trauma network is fully implemented; and be it further

RESOLVED, That there be recognition of non-emergency transportation vehicles to be used in routine patient transfer, which vehicles will be limited to providing only non-emergency medical transportation.

Resolution 72M-10

Introduced by: Eugene F. Diamond for the Nutrition Committee

Subject: Vitamin C and the Common Cold

Referred to: Reference Committee on Environment, Community and Mental Health

WHEREAS, largely as a result of a recent book, *Vitamin C and the Common Cold*, by Dr. Linus Pauling, large doses of Vitamin C for the prophylaxis and cure of the common cold has been recommended; and

WHEREAS, there is currently insufficient evidence that ascorbic acid in the doses recommended by Dr. Pauling is either safe or efficacious in the prevention or treatment of the common cold; therefore be it

RESOLVED, That until data are available proving the safety and efficaciousness of Vitamin C for the prophylaxis and cure of the common cold are available, the members of ISMS be informed that the use of ascorbic acid for this purpose is not recommended.

Resolution 72M-11

Introduced by: Eugene F. Diamond for the Nutrition Committee

Subject: Response to Resolution 71M-46; Support of Low Standard Budget

Referred to: Reference Committee on Environment, Community and Mental Health

WHEREAS, the Nutrition Committee has considered House of Delegates Resolution 71M-46, which called for ISMS endorsement of the U.S. Bureau of Labor Statistics Low Standard Budget; and

WHEREAS, the Nutrition Committee in its 1970 report to the House of Delegates recommended the IDPA food allowance be increased to conform with the U.S. Department of Agriculture low cost plan; and

WHEREAS, the House of Delegates in 1970 modified the Nutrition Committee recommendation to endorse the USDA medium cost plan; and

WHEREAS, the adoption of this by the 1970 House of Delegates has already accomplished the intent of Resolution 71M-46; therefore be it

RESOLVED, That Resolution 71M-46 be filed for record since the action of the 1970 House of Delegates has already accomplished the intent.

Resolution 72M-12

Introduced by: Edward A. Piszczek for the Council on Environmental & Community Health

Subject: Policy on Automated Multiphasic Health Testing and Screening

Referred to: Reference Committee on Environment, Community and Mental Health

WHEREAS, it is important that methods be utilized which enable the physician to compile information relative to his patients as efficiently as possible; and

WHEREAS, during the recent past there has been an increase in various Automated Multiphasic Health Testing and Screening Programs, and

WHEREAS, there is a place for Computer and Automated Multiphasic Testing and Screening Programs as an extension of the services available to the physician as he considers each individual case; and

WHEREAS, the use of the results of such testing must be under the direct control and review of a physician, therefore be it

RESOLVED, That the Illinois State Medical Society endorse the principle of Automated Multiphasic Health Testing and Screening Laboratories and Programs as an extension of the services available to a physician as such pertain to the health needs of an individual patient; and be it further

RESOLVED, That this statement be included in the Policy Manual of the Illinois State Medical Society, and the Position Statement on Automated Multiphasic Testing and Screening developed by the Council on Environmental and Community Health and the AMA Guidelines for Establishing and Operating MHT Program be endorsed and included as an appendix to the Policy Manual.

MULTIPHASIC HEALTH TESTING COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomatic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health

and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination of medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom of choice between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual

or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

GUIDELINES FOR ESTABLISHING AND OPERATING MULTIPHASIC HEALTH TESTING PROGRAMS

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians should be involved in the planning and development of testing programs, and the operation of all programs should be supervised by qualified physicians.
4. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
5. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable sensitivity, specificity, high predictive value, and patient acceptance.
6. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
7. The program should provide for confidentiality of patient data.
8. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
9. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
10. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
11. The program should maintain freedom of choice for both the physician and the patient.

Resolution 72M-13

Introduced by: Robert R. Hartman for the Maternal Welfare Committee

Subject: Professional Nurse-Midwives

Referred to: Reference Committee on Education and Manpower

WHEREAS, there exists an increasingly severe shortage of physicians practicing obstetrics; and

WHEREAS, good prenatal care has come to be recognized as a sine qua non of good obstetrical care; and

WHEREAS, the signs of incipient complications of pregnancy, labor, and delivery are, for the most part, easily recognized; and

WHEREAS, the Professional Nurse-Midwife, as referred to in this resolution, is a registered nurse who has completed a program of nurse-midwifery education approved by the American College of Nurse Midwives and as a result has been certified competent to practice as a Professional Nurse-Midwife within the medical model; and

WHEREAS, there are currently eleven schools for Professional Nurse-Midwives in the United States, plus one pending in Illinois; and

WHEREAS, the American College of Nurse-Midwives in conjunction with the American College of Obstetricians and Gynecologists have jointly endorsed the role of the Professional Nurse-Midwife who meets accreditation standards; therefore be it

RESOLVED, That the Illinois State Medical Society supports the establishment of educational programs for Professional Nurse-Midwives and the utilization of Nurse-Midwives in obstetrical programs and services in accordance with standards established by the American College of Nurse-Midwives.

Resolution 72M-14

Introduced by: Edward A. Piszczek, M.D.

Subject: Control of Venereal Disease

Referred to: Reference Committee on Environment and Community and Mental Health

WHEREAS, the Illinois Department of Public Health seeks to improve the reporting of venereal disease, especially gonorrhea, and

WHEREAS, the epidemic being caused by gonorrhea requires that all practicing physicians consider this as a possible diagnosis, especially in sexually active people, and

WHEREAS, the lack of diagnosis of such cases in females represents an obstacle which prevents the use of appropriate control measures and helps to continue this epidemic, and

WHEREAS, the Illinois Department of Public Health recognizes this as a major health problem, therefore, be it

RESOLVED, that the Illinois State Medical Society supports the program of the Illinois Department of Public Health, in its efforts to identify undetected cases of venereal disease, especially gonorrhea as a method of halting the alarming rise in these diseases in Illinois.

Resolution 72M-15

Introduced by: E. T. Leonard, M.D., Winnebago County Medical Society

Subject: ISMS Dues Exemption for Members Over Age 70
Referred to: Reference Committee on Public Relations and Miscellaneous Business

WHEREAS, The American Medical Association requires no membership investment (dues) from any member physician who has achieved 70 years of age, and

WHEREAS, This same exemption is not currently available to all physician members of the Illinois State Medical Society who have reached the age of 70, and

WHEREAS, It would be desirable to structure some consistency in the membership investment (dues) between the American Medical Association, Illinois State Medical Society and the local Medical Society, and

WHEREAS, We should recognize the long contribution of these fine physicians who have supported the profession during the past years, therefore be it

RESOLVED, That the Illinois State Medical Society concur in the principle of exemption from dues for any members, upon request, on January 1st following his 70th birthday, and be it further

RESOLVED, That component medical societies be encouraged to offer similar opportunities to local physicians.

Resolution 72M-16

Introduced by: E. T. Leonard, M.D., Winnebago County Medical Society

Subject: Equal Recognition for Military Service

Referred to: Reference Committee on Public Relations and Miscellaneous Business

WHEREAS, The American Medical Association has three classifications of direct members:

1. Service Members
2. Physicians employed by Federal Agencies
3. Hospital interns and residents, and

WHEREAS, Those direct members in category three of hospital interns and residents, rightfully enjoy an exemption of payment of total or partial membership dues, and

WHEREAS, This exemption for interns and residents continues until January of the next calendar year following the termination of their residency, and

WHEREAS, The service members do not enjoy this same exemption until the end of the current year, and

WHEREAS, Those physicians who have had their professional careers interrupted by service to their country should be afforded the same benefits, privileges and courtesies, therefore be it

RESOLVED, That the Illinois State Medical Society institute the policy of equal benefits available to those who have served their country by establishing an exemption for dues for service members with the same rights and privileges as intern and resident members, and, be it further

RESOLVED, That the Illinois State Medical Society Delegates to the American Medical Association be requested to carry this Resolution and its intent to the House of Delegates of the American Medical Association for their consideration.

Resolution 72M-17

Introduced by: E. T. Leonard, M.D., Winnebago County Medical Society

Subject: Commendation

Referred to: Officers and Administration

WHEREAS, The physicians and staff of the Illinois Foundation for Medical Care have established a forward looking posture for medicine in the health care delivery system by the counter proposal of HASP to the State of Illinois and the Illinois Department of Public Aid, and

WHEREAS, The physicians of Illinois were in the favorable posture of presenting a positive proposal for specific action to work towards solution of the problems involving health care delivery financing programs of the State of Illinois, and

WHEREAS, The ability to respond in a fast, effective

and knowledgeable manner reflects credit upon the physicians and their staff, therefore be it

RESOLVED, That the members of the House of Delegates of the Illinois State Medical Society, in representation of Illinois physicians, compliment the physicians and staff of the Illinois Foundation for Medical Care on their hard work and intense involvement, and be it further

RESOLVED, That the House conveys its warm wishes of continued leadership in the Foundation concept.

Resolution 72M-18

Introduced by: Morgan Meyer, M.D., Delegate, Du Page County Medical Society

Subject: Interprofessional Society for Sponsoring a Legal Rights Team

Referred to: Reference Committee on Governmental Affairs and Medical-Legal.

WHEREAS, compulsory health programs in many countries have caused deterioration in the quality of medical care and such programs are now being proposed in the United States, and

WHEREAS, the same encroaching control of all professions is being proposed in the United States, and

WHEREAS, the ability of the American Medical Association to influence adjudication and legislation would be much greater if combined with all other professionals, be it therefore

RESOLVED, that the Illinois State Medical Society urge the American Medical Association to join dentists, lawyers and other professionals to form a multi-disciplinary Professional Rights Society, funding a team of lawyers, charged with protection of rights of professionals from coercive government encroachment, by vigorous litigation whenever legislation threatening such rights is proposed, and be it further

RESOLVED, that the Professional Rights Society and its legal staff be supported by a \$10 assessment upon each member of the American Medical Association.

Resolution 72M-19

Introduced by: Morgan Mayer, M.D., Delegate Du Page County Medical Society

Subject: Appointment of Ad Hoc Search Committee

Referred to: Reference Committee on Officers and Administration.

WHEREAS, Most state society offices are filled by members who have served for many years in various capacities at a local and state level, and

WHEREAS, Such officers coming through the ranks are thus of necessity past the middle years of age, and

WHEREAS, Organized medicine now faces increasing division within its ranks on the basis of youth-related versus maturity-related health philosophies, be it therefore

RESOLVED, That the Illinois State Medical Society Board of Trustees appoint an Ad Hoc Search Committee to seek out young, vigorous and articulate members who can project a good public image, and encourage them to serve as state society officers, without spending years of service rising through the ranks, and be it further

RESOLVED, That the Illinois State Medical Society Board of Trustees urge and encourage the American Medical Association to also appoint such a committee with the same purpose.

Program Summary by Days

(Preliminary)

Monday March 6, 1972

6:00 p.m. ISMS Board of Trustees Dinner and Meeting

Tuesday March 7, 1972

7:45 a.m. AMA Delegates Breakfast
8:30 a.m. Delegates Registration
10:00 a.m. ISMS District Caucuses
3:00 p.m. House of Delegates
5:30 p.m. Delegates Buffet
7:00 p.m. Reference Committees—
Constitution & By-Laws
Officers & Admin.
Finances, Publications
Governmental Affairs
Education & Manpower
Environmental & Com Health
Economics & Peer Review
Public Relations

Wednesday March 8, 1972

8:00 a.m. Registration Opens
CIMA Breakfast
8:30 a.m. Board of Trustees Meeting
9:00 a.m. Quality Control-Office
Basic and Advanced Money Management Seminar
Instruction Course-Surgery
Pediatric Mental Health Seminar
Medical Movies
11:00 a.m. Quality Control-Hospital
Noon Chicago Pediatrics Luncheon
12:15 p.m. Illinois Academy of Family Physicians Luncheon
12:30 p.m. Chicago Laryngological and Otological Society Round Table Luncheon
1:00 p.m. Pathology Luncheon
2:00 p.m. ISMS Committee on Aging—program
Pediatrics—program
Laryngological and Otologic Sessions
German Medical Society Round Table
6:00 p.m. ISMS Public Affairs Dinner

Thursday March 9, 1972

7:30 a.m. Auxiliary-IMPAC Breakfast
8:00 a.m. CIMA Breakfast
Registration Opens
8:30 a.m. ISMS Board of Trustees Meeting
9:00 a.m. Medical Science Writers Seminar

- Instruction Course Ob-Gyn
Trauma—Session
Professional Activities Study
Medical Movies
- 10:00 a.m.** Medicine & Religion—program
- 11:00 a.m.** Illinois Society of Internal Medicine
Chicago Society of Allergy
- Noon** 50-Year Club Luncheon
Luncheon—Executive Committee, Illinois
Chapter, American College of Radiology
- 12:30 p.m.** Illinois Chapter, American College of Chest
Physicians Round Table Luncheon
Chicago Society of Plastic Surgery Round
Table Luncheon
- 2:00 p.m.** Radiology—Program
Illinois Chapter, American College of
Chest Physicians
Chicago Society of Plastic Surgery
House of Delegates
- 4:15 p.m.** Business Meeting and Reception-Radiology
- 5:30 p.m.** Reception and Dinner-Chicago Society of
Plastic Surgery
- 6:00 p.m.** President's Dinner

**Friday
March 10, 1972**

- 7:30 a.m.** Round Table Breakfast-Family Planning
Illinois Ob-Gyn Society
- 8:00 a.m.** CIMA Breakfast
Registration opens
- 8:30 a.m.** Operative Clinics-Cook County
Board of Trustees
- 9:00 a.m.** Program by IRMP (Problem Oriented
Record)
Instruction Course-Medicine
Medical Movies
- 10:00 a.m.** House of Delegates
- 11:00 a.m.** Chicago Gynecological Society and Illinois
Ob-Gyn Society
- Noon** Illinois Academy of Physical Medicine
and Rehabilitation—Luncheon
- 12:30 p.m.** Round Table Luncheon - Ob-Gyn
- 1:30 p.m.** Chicago and Illinois Surgical Societies
Impartial Medical Testimony—program
Annual Meeting—Illinois Foundation for
Medical Care
- 2:00 p.m.** Chicago Pediatric Society
Illinois Psychiatric Society
Chicago Orthopedic Society
- 6:00 p.m.** Reception and Dinner, Chicago Surgical
Society
Board of Trustees Dinner
Chicago Orthopedic Society Dinner

**Saturday
March 11, 1972**

- 9:00 a.m.** Instruction-Pediatrics
Chicago Society of Anesthesiologists
Student American Medical Association

POSTGRADUATE COURSE

INTERNAL MEDICINE

SHERATON-BLACKSTONE HOTEL

636 South Michigan Avenue

March 6, 7, 8, 1972

a uniquely-structured, intensive Postgraduate Course in six important areas of Internal Medicine. The six outstanding medical schools in Chicago have taken the responsibility for detailing the latest developments in each of these areas. Individual segments begin with a "State of the Art" address after which the group will be separated into five discussion groups with outstanding faculty where the learning potential will be at its maximum.

As a "fringe benefit," registrants are invited to stay the balance of the week and participate in the combined meetings of the Midwest Clinical Conference sponsored by the Chicago Medical Society and the Annual Meeting of the Illinois State Medical Society.

HEMATOLOGY

Moderator: Maxwell P. Westerman, M.D., Professor of medicine and Director, Division of Hematology, Mount Sinai Hospital and Chicago Medical School

CARDIOLOGY

Moderator: Leon Resnekov, M.D., Professor, Department of Medicine; Co-Director, Division of Cardiology, Department of Medicine, University of Chicago Pritzker School of Medicine

ONCOLOGY

Moderator: Charles P. Perlia, M.D., Associate Professor of Medicine, Rush Medical College

GASTROENTEROLOGY

Moderator: Earl Dordal, M.D., Associate Professor, Department of Medicine, Northwestern University Medical School

CLINICAL IMMUNOLOGY AND RHEUMATOLOGY

Moderator: Herbert Rubenstein, M.D., Professor, Department of Medicine, Loyola University Stritch School of Medicine

INFECTIOUS AND PULMONARY DISEASES

Moderator: Ruy V. Lourenco, M.D., Professor of Medicine, Director of Pulmonary Section, Department of Medicine, University of Illinois College of Medicine

PROMPT REGISTRATION IS RECOMMENDED

CHICAGO MEDICAL SOCIETY

THE MEDICAL SOCIETY OF COOK COUNTY

310 South Michigan Ave.

Chicago, Illinois 60604

Date

Please enroll me for the 1972 Postgraduate Course in Internal Medicine

I enclose the registration fee of \$100

Check ☐

Money Order ☐

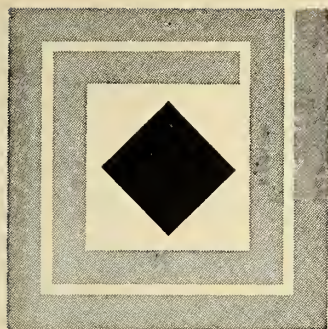
Name

Street

City and State Zip

Member of County Medical Society

Type of Practice



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



Fig. 1



Fig. 3



Fig. 2

This 60-year-old patient entered the hospital with complaints of a 30-pound weight loss and vomiting. Physical examination was unremarkable. A cone down film of the left upper quadrant was obtained.

What's your diagnosis?

(Answer on page 236)



surgical grand rounds

EDITED BY JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial, and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of November 9, 1971.

Adrenal cyst



Fig. 1. Nephrotomogram demonstrates a left suprarenal mass.

Case Report:

Dr. Robert Bass: The patient is a 65-year-old man who was admitted to Chicago Wesley Memorial Hospital because he had dysuria, frequency of urination, and was found to have bladder neck obstruction. Physical examination was unremarkable. Vital signs were normal. When rectal examination was performed, the prostate was smooth and symmetrically enlarged. Laboratory studies include blood count and urinalysis which were within normal limits. Additional laboratory tests included cortisone levels which were within normal limits. Abnormalities detected by roentgenographic examination were of interest.

Dr. Harold Matthies: Because a suprarenal mass was seen on outside films, a nephrotomogram was our first diagnostic procedure. Here we see the suprarenal mass separate from the kidney and presumably representing an adrenal lesion (Fig. 1). Additional possibilities are pancreatic pseudocysts and splenomegaly. On the upper gastrointestinal study the stomach was displaced an-

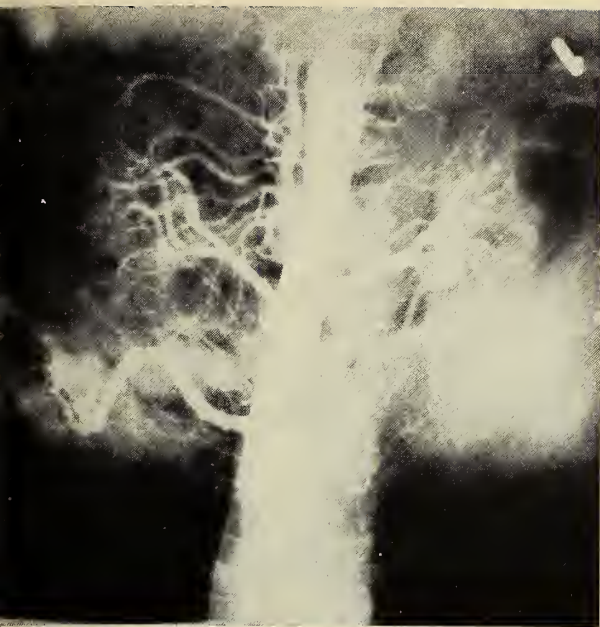


Fig. 2. Aortogram shows good filling of splenic artery as well as renal arteries but the suprarenal mass is not visualized.

teriorly and a little laterally. Selective arteriography was done and showed the splenic artery and a normal spleen (Fig. 2). There was no tumor vascularity in association with this suprarenal mass and it is presumed that this is not

a tumor because there were no tumor vessels. It was concluded that this most probably represents a cystic lesion of the left adrenal.

Dr. Hines: What would a tumor look like?

Dr. Matthies: A tumor would have feeding vessels and would have demonstrated a tumor blush and early filling of the venous side caused by arterial venous shunting.

Dr. Thomas Kornmesser: A left paramedian incision was made because adrenal carcinoma might be present. The colon and spleen were mobilized and rotated anteriorly and medially. A cystic mass was found in the region of the left adrenal and was excised. It appeared to be in the adrenal gland itself.

Dr. Joseph C. Sherrick: The specimen was an adrenal which was mostly replaced by a 5 cm cyst (Fig. 3), containing a fresh blood clot. The cyst had a smooth, glistening lining, and the branches of the central adrenal vein were prominent in this wall. Sections showed that the cyst was lined by flattened cells, somewhat resembling endothelial cells. In the wall of the cyst there were small, empty spaces resembling dilated lymphatics (Fig. 4), and in a few areas identifiable bundles of smooth muscle were present. The pathological diagnosis was lymphatic cyst of the adrenal. This lesion is not a pseudocyst because there is no evidence of hemorrhage in the wall and because there is no fibrous tissue

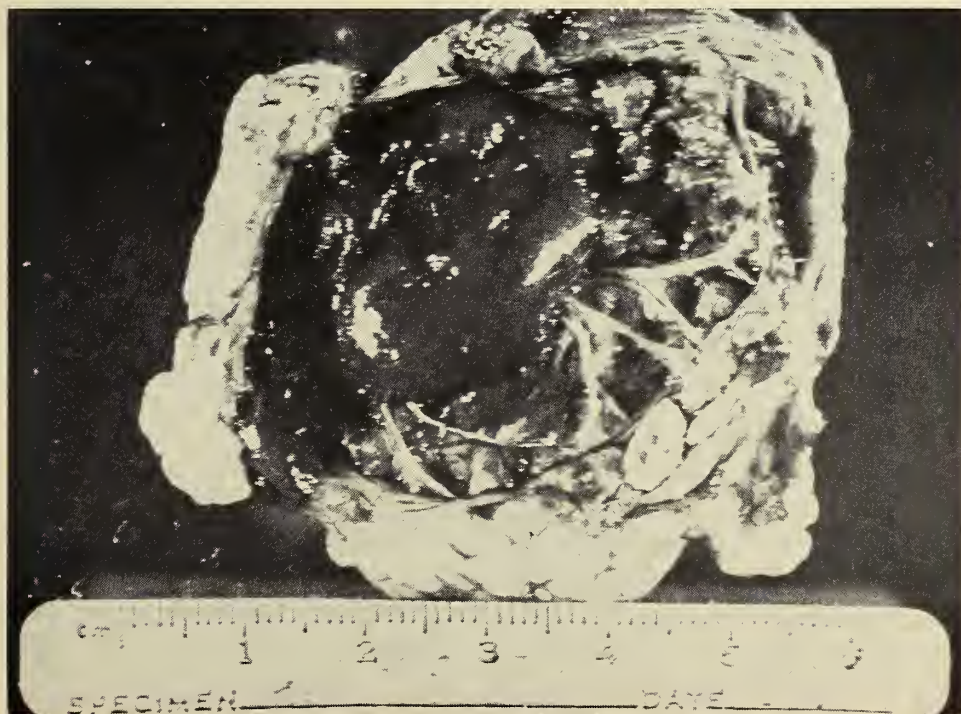


Fig. 3. The adrenal cyst has been opened and contains a blood clot.

Adrenal cyst

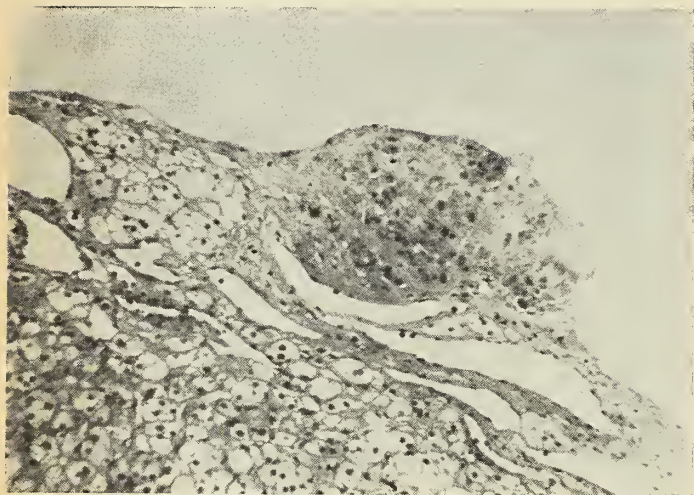


Fig. 4. The dilated spaces in the wall of the cyst establish the diagnosis of lymphatic cyst of the adrenal.

reaction around the cyst. The fresh blood clot which the cyst contained is concluded to be related to recent trauma, possibly occurring during the surgical procedure.

Dr. Thomas Kornmesser: Adrenal cyst is a rare clinical and pathological entity. Greiseliuss in 1670, described the first, and since then about 150 clinical and about 100 autopsy cases have been reported. Pathologically, the parasitic cysts, which are usually echinococcal in nature, represent about seven per cent of the total number. Epithelial cysts, which are so-called congenital cysts, constitute approximately nine per cent of the total. These include retention cysts, embryonal cysts, or cystic adenomas. The third type are the endothelial cysts which include the

**This photograph was loaned by Dr. Hector Battifora of Chicago Wesley Memorial Hospital.*

lymphangiomatous and angiomatous types. Our case was an example of the former. The endothelial cysts comprise about 45% of the total group. The last type is the pseudocyst and makes up about 40% of the adrenal cysts. It is the most common type found clinically.

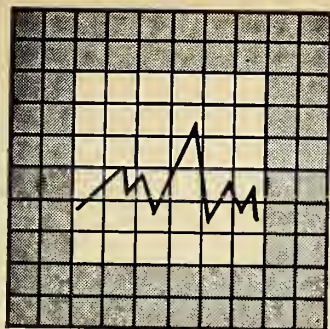
The patients may be anywhere from newborn to 70-years-of-age, and the ratio of female to male is 3:1. The cysts occur equally on the right and left side. Symptomatically, they occasionally present with a dull pain in the adrenal area with gastrointestinal symptoms or a palpable mass. Occasionally, systemic symptoms such as weight loss occur. Diagnosis is made either by physical examination (noting the location of the mass), the use of the intravenous pyelogram, nephrotomogram, aortogram, and/or retroperitoneal insufflation. Specific chemical findings are not present. Cysts are usually considered to be nonfunctioning tumors in the adrenal preoperatively, and are often operated on with a diagnosis of carcinoma. The differential diagnosis consists of tumor of the adrenal gland, cysts of the spleen, cysts of the liver, pseudocyst of the pancreas, kidney tumors, and aneurysms of renal artery and aorta. The treatment of choice is excision with preservation of the kidney on that side, and can be performed in most patients. Marsupialization has been done, as have incision and drainage. The approach may be through the peritoneal cavity, (as we did in our case) a lumbar incision and retroperitoneal approach, or transthoracic approach.

Reference

1. Foster. D. G.: "Adrenal Cysts," *Arch. Surg.*, 92:131, 1966.

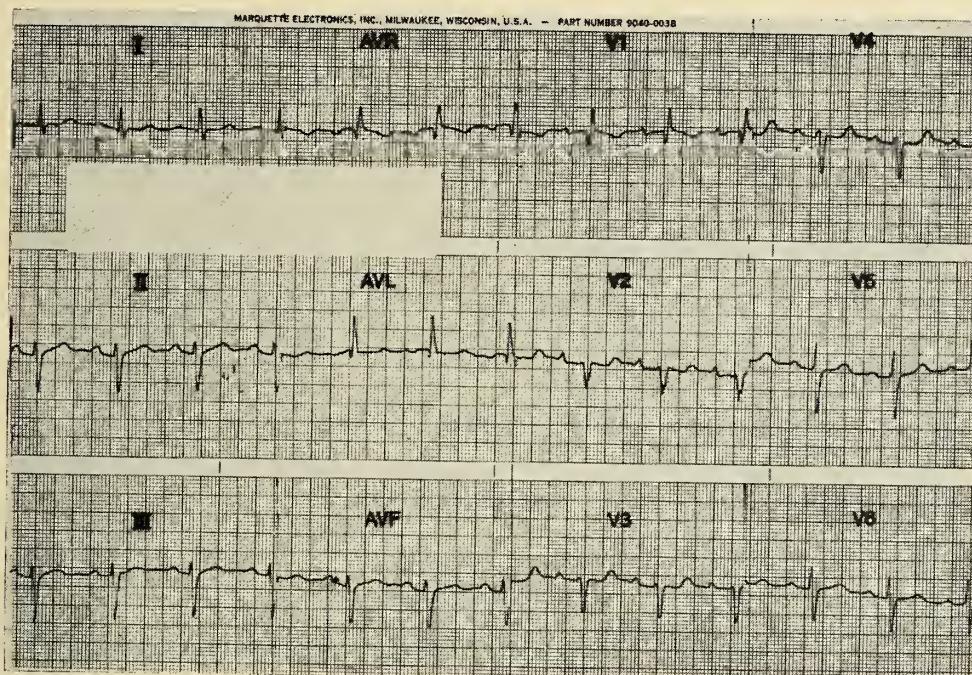
Conquer the killers!

"The past three decades have seen a fantastic explosion of medical knowledge. There has been such a fabulous growth of skills, techniques and information that even our greatest medical scientists hesitate to predict the date and manner in which the killer diseases will be conquered. It may be sooner than we think." (Wesley W. Hall, M.D., AMA president: "By Uniting We Stand. . . ." Address presented at AMA Annual Convention, June 23, 1971.)



ekg of the month

JOHN R. TOBIN, JR., M.D., M.S., RIMGAUDAS NEMICKAS, M.D.,
PATRICK SCANLON, M.D., JOHN F. MORAN, M.D. AND JAMES
V. TALANO, M.D./SECTION OF CARDIOLOGY,
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This 23-year-old housewife developed increased fatigability during the past few years, and mild dyspnea on exertion for the past one year.

Examination revealed a healthy appearing young woman. Blood pressure 110/80, pulse was 84 and regular. There was no cyanosis or clubbing. Precordial activity was increased. S_1 was normal, but followed by an ejection click, and a grade II/VI systolic ejection murmur at the upper left sternal border. S_2 was widely split and did not vary with respiration. A short diastolic rumble was heard at the lower left sternal border. At the apex a grade II/VI pansystolic murmur was heard.

Questions: (One or more of the choices may be correct.)

- A. The electrocardiogram shows:
 1. Left ventricular hypertrophy.
 2. Left axis deviation.
 3. Right ventricular hypertrophy.
 4. True posterior myocardial infarction.
 5. None of the above.
- B. The following clinical diagnoses are probable.
 1. Atrial septal defect of the ostium secundum type.
 2. Atrial septal defect of the ostium primum type.
 3. Mitral regurgitation.
 4. Mitral stenosis.
 5. All of the above.

(Answer on page 236)



editorials

The treatment of gonorrhea in the female

YOU HAVE LISTENED to reports of the pandemic gonorrhea ad nauseum. We will not bore you with statistics or philosophy. We will only confirm that everything you have read and heard is quite true. There is an epidemic! Our attention will be concentrated on what you, the physician, can and must do in the way of diagnosis and treatment.

The diagnosis

There are several basic considerations you should be mindful of:

1. Uncomplicated gonorrhea in the female is generally asymptomatic.
2. The smear in the female is usually of little value.
3. The diagnosis of gonorrhea can only be made on culture—this means everyone with a high index of suspicion, with or without symptoms, must be cultured. We know that gonorrhea is most common in women with liberal sex attitudes and voracious sex appetites, in those with poor educational and socio-economic backgrounds, and those with vaginitis. Even without a history of possible or probable exposure to gonorrhea, this "high risk" population should be cultured. In some groups, especially the underprivileged between the ages of 15 and 29, the incidence of asymptomatic gonorrhea is 30%. Even in the super socio-economic strata, the fancy-panties, the incidence is 1.5 to 3%. So if we are to get rid of g. c. we must look for it in its reservoir—the asymptomatic female.
4. Anorectal infection often occurs. It can only be diagnosed by being aware of this possibility and taking anal cultures.



With the permission of Riksförbundet för Sexuell Uppllysning, Stockholm.

Until recently the Thayer-Martin medium (with candle jar) was the best available. It was cumbersome and the culture seldom lived over 24-48 hours without being transplanted.

Now we have a new medium which has proven eminently more satisfactory. It is a modification of the Thayer-Martin medium and has been called Transgrow by its originators, Martin and Lester. Transgrow is not a specific trade name. It is prepared by many different laboratories. It contains an atmosphere of CO₂, which is essential for the growth of the gonococcus. The medium can be stored for months at room temperature, even longer in the refrigerator. It is "good" as long as it does not appear dried out and there is no evidence of surface growth. As long as the screw cap is secure, the CO₂ atmosphere is maintained.

If Transgrow has been stored in the refrigerator, it should come to room temperature before using (at least 30 minutes). After swabbing the surface of the medium, the cap is replaced and tightened, and the bottle is mailed to the laboratory. The organisms should remain viable up to 96 hours in transit. On arrival in the laboratory the flask is incubated at 35° C for 16-24 hours and examined. If incubation has been made for 16-18 hours before mailing, the specimen will be ready for examination when it reaches the laboratory. Presumptive identification depends upon the presence of Gram-negative diplococci and tests for oxidase production.

En passant, about 10% of males with gonorrhea are also asymptomatic; at least the male doesn't recognize his infection.

Achieving gonorrhea control

Having established the diagnosis, we still have two important objectives if gonorrhea control is to be achieved:

1. *To properly treat the patient.* The sheet anchor in the treatment of acute gonorrhea in the female (with or without symptoms) is 4,800,000 units of aqueous procaine penicillin G given at one time—2.4 mu in each buttock. (Wyeth markets a disposable 4 ml syringe containing 2.4 mu.) Recently, Johnson et al, have suggested that the dose be increased to 6 mu parenterally. Certainly this increase in the established 4.8 mu can do no harm.

Other medications are also used—both orally and parenterally—especially when the patient is sensitive to penicillin. Unfortunately, when we turn to other antimicrobial agents, the recommended regime often seems to vary with the in-

vestigator—most of whom report a cure rate of about 95% whatever they use. To go into detail will only cause confusion. Hence, little will be said for other therapies except to call their existence to your attention.

Ampicillin is a derivative of penicillin which can be given orally if the patient is not penicillin sensitive. But the only real advantage is the avoidance of the injection. Against this there is the great disadvantage of not knowing whether the oral medication will be taken at all or even retained after swallowing. Since the recommended dosage varies and the ampicillin really possesses no merit, except for mode of administration, over penicillin, we strongly urge the parenteral use of penicillin, whether 4.8 or 6 mu is immaterial, in all patients who are not allergic to penicillin.

Probenecid, one gram, orally one hour before either penicillin or ampicillin, appears to enhance the effectiveness of either antibiotic by delaying its excretion. However, the true value to this adjunctival treatment is not established.

Cephaloridine, kanamycin, and spectinomycin are also effective antibiotics. The dose is generally from 2-4 gms. given intramuscularly at a single session.

In patients with a history of penicillin hypersensitivity, tetracycline therapy is substituted as a second best and less effective regime. A recommended initial dose of 1.5 gms. orally is followed by 0.5 gm. orally every four to six hours for four days until a total dose of 9.0 gms. has been given.

Analogues and derivatives of tetracycline such as doxycycline, minocycline and oxytetracycline also are effective agents against the gonococcus, but really have little to offer not obtained with tetracycline. The suggested dosage varies from study to study. Doxycycline may be given as a single dose of 300 mg or in divided doses of 100 mg twice a day for three to four days.

For acute and/or chronic salpingitis, it is recommended that 6 million units of aqueous procaine penicillin G be given intramuscularly daily for seven days; for anorectal gonorrhea, 6 million units of APP intramuscularly daily for four days; and for gonococcemia, arthritis and endocarditis, 10 million units of crystalline penicillin G are given daily intravenously for seven to 14 days. Obviously, these latter doses are suggested as a guideline and only for patients not sensitive to penicillin.

Benzathine penicillin G is used in the treatment of syphilis, not gonorrhea. It does not reach the necessary blood level to be effective in the

Gonorrhea in the female

treatment of gonorrhea even though the duration of action persists for days.

The preceding regimes are for the female. Acute gonorrhea in the male responds well to 2.5 million units of aqueous penicillin G, intramuscularly at one site, or its equivalent if substituted drugs are indicated because of sensitivity.

The treatment of syphilis requires long acting benzathine penicillin G. Thus, the short-acting, aqueous procaine penicillin G is not effective in the active treatment of syphilis. However, it does seem to be of value prophylactically when the patient who is treated for gonorrhea also had been exposed to syphilis.

As a rule it is wise to check the VDRL not only when the diagnosis of gonorrhea is made, but also six and twelve weeks after treatment.

2. *Work with local health authorities.* This is to insure that treatment is carried out and to aid in tracing and treating all contacts, whether the source of the infection, or those exposed and to whom it might have been spread.

Health officials are always discreet. There should never be any anxiety over possible dis-

closure of confidential information. In addition, the V.D. section of local health departments is usually very knowledgeable and most helpful and cooperative in aiding the physician and/or his patient with problems related to treatment and control.

As a final thought, remember that the *birth control pill does not prevent gonorrhea or any V.D.* Actually it helps to spread venereal diseases by reducing the popularity of the condom—which did give fairly good protection for both male and female—and by apparently providing a more receptive environment in which the venereal infection can develop.

Edwin J. DeCosta, M.D.
Professor, OB-GYN

Northwestern University Medical School

Reference

1. Johnson, D. W., Kvale, P. A., Afable, V. L., Stewart, S. D., Halvorson, C. W. and Holmes, K. K.: "Single-Dose Antibiotic Treatment of Asymptomatic Gonorrhea in Hospitalized Women," *N. Eng. J. Med.*, 283:1, 1970.

Over-protecting her doctor

Secretaries and wives can be overprotective towards their doctors, so much so that it becomes quite a problem to see the doctor. One Tuesday morning a friend rang up her G.P. to make an appointment that evening. "The doctor can not see you today," was the crisp, almost joyous rejoinder, "Nor can he see you any day this week." People who put in emergency calls after hours are sometimes so intimidated; a very sick patient can be neglected. A friend of a young doctor had a different problem with her G.P.'s receptionist. She would ring up and ask for an appointment to have one of her small children seen, and she was then questioned about signs and symptoms and finally told to call for a prescription. In the course of 12 months she never managed to see the doctor, and such is the loyalty of the public to our profession she had to have her medical friend's assurance that it was reasonable to change over to a doctor who was more accessible. Apart from emergency cases, which must be seen promptly, and cases that are clearly not urgent, all patients in general practice should be seen by some doctor in the firm in 24 hours, and all outpatients at hospitals should be seen in a week. (C.A.H. Watts.: "The Hot Line," *Brit. Med. J.*, Aug. 14, 1971, pgs. 419-421.)



practice management

Follow it up! The unpaid bill

BY JAMES N. ANSTETT, CONSULTANT
PROFESSIONAL BUSINESS MANAGEMENT, INC.

As we mentioned in an earlier article, an unpaid bill is an open sore. Most patients who fail to pay these bills are those who are living beyond their means. One method of educating delinquent patients is the utilization of a collection follow-up system. Besides the financial aspects of the follow-up, it also has a public relations value. A patient who owes you money may often belittle you to his friends.

While there are several different methods of following up on delinquent accounts, there is a single underlying philosophy behind them all: educating the patient that the doctor expects to be paid, or at least told why he cannot expect payment and when such payment might be forthcoming.

Of the many methods, there are several which are the most common: direct telephone contact; stickers; inserts; and letters, either individually written or form letters. We shall examine some of the pros and cons of each of these procedures.

The most personal of the follow-up methods mentioned is the personal call. Under ideal conditions, this is the best available way. However it has many drawbacks. First of all, there is the obvious expenditure of time by the aide who will often have trouble reaching the responsible party. Even if she does reach him, he may not be in a receptive mood for such a call and "shut off" anything she says and make vague promises of payment. There is also the problem that many aides are not experienced enough to cope with the creditor curves thrown at them.

Probably the most common method of follow-up is the use of stickers. While this is a simple and inexpensive way of informing delinquents,

it lacks the personal touch that most patients expect from their doctor. After all, there are few relationships in this life more intimate than that of doctor and patient. Besides, stickers have become so common-place that most people ignore them completely.

An insert, if properly designed, can be another effective means of following up. Since it is a separate sheet from the bill, it almost "forces" the patient to read it. It is as easy to use as a sticker and a little more professional.

Next to the telephone call, a letter is the most personal method of follow-up. It is also the most expensive, especially if individually dictated and typed letters are used. Form letters, on the doctor's letterhead, and designed to cover several general situations have proven to be an excellent system. Letters have the advantage over both stickers and inserts in that the delinquent patient receives two separate pieces of correspondence from the doctor during the month in question. Often there is a section in the letter where the patient may indicate a method of payment and then return it to the doctor. Thus, the doctor will now have a written promise from the patient to keep on file.

Whichever type of follow-up you choose to use, there are some important points to remember. First, use it consistently and on a continuing basis. Be firm but compassionate with delinquents. And, last, follow-up any and all past due accounts where there has been no indication of why the patient cannot pay or has not made arrangements for paying. You were trained to be a doctor, not a mind reader!

Rx Product Index

<i>Alpha-Kerri</i> .....221	<i>Pfizerpen VK</i> .....124-125
Westwood Pharmaceuticals, Inc.	Pfizer Laboratories, Pfizer Inc.
<i>Donnagel/Robitussin</i> .....108	<i>Premarin</i> .....126-127
A. H. Robins Company	Ayerst Laboratories Div.
<i>Empirin w/Codeine</i> .....2nd Cover	American Home Products, Inc.
Burroughs Wellcome & Co.	<i>Synthroid</i> .....104-105
<i>Hydergine</i> .....118-119	Flint Laboratories
Sandoz Pharmaceuticals	<i>Tepanil/Quinamm</i> .....209-210
<i>Kinesed</i> .....102-103	Merrell-National Laboratories
Stuart Pharmaceuticals	<i>Trobicin</i> .....120-121
Division of I.C.I. America, Inc.	The Upjohn Company
<i>Librium</i> .....112-113	<i>V-Cillin K, Pediatrics</i> .....128
Roche Laboratories	Eli Lilly & Co.
<i>Mylanta</i> .....99	<i>Valium</i> .....Back Cover
Stuart Pharmaceuticals	Roche Laboratories
Division of I.C.I. America, Inc.	<i>Vasodilan</i> .....114-115
<i>Orinase</i> .....110-111	Mead Johnson & Co.
The Upjohn Company	<i>Versapen-K</i> .....100
<i>Ornade</i> .....123	Bristol Laboratories
Smith Kline & French	

ANOTHER **ISMS** MEMBERSHIP PRIVILEGE LOW-COST GROUP INSURANCE

GROUP DISABILITY PLAN

- **NEW**—Guaranteed renewable feature
- Sickness benefits to age 65
- Up to \$250.00 weekly benefits

(PROTECT YOUR INCOME AND SECURITY)

GROUP SUPER MAJOR MEDICAL PLAN

- Up to \$50.00 daily room and board
- Up to \$25,000 for each accident or sickness
- In hospital and out of hospital expenses

(TRULY CATASTROPHIC PROTECTION)

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, MESSIAH & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Overeating vs. your heart and arteries

Additional important evidence regarding the relationship of over-eating to hardening of the arteries and heart attacks was presented in November by two doctors from The University of Chicago at the American Heart Association Meeting in Anaheim, California.

It has been suspected for many years that excessive eating increases the chances of contracting these ailments, according to Doctors Katti R. Dzoga and Dragoslava Vesselinovitch, research associates and assistant professors in the Department of Pathology at the University.

They are members of a team studying the effects of blood fats on aortic tissue culture cells. They are now experimenting to determine what particular fraction of fat in the blood is responsible for the changes in the cells of arteries which lead to atherosclerosis (hardening of the arteries).

Their research has indicated that high-fat diets cause acceleration of atherosclerosis, since the aortic cells grow at a more rapid pace.

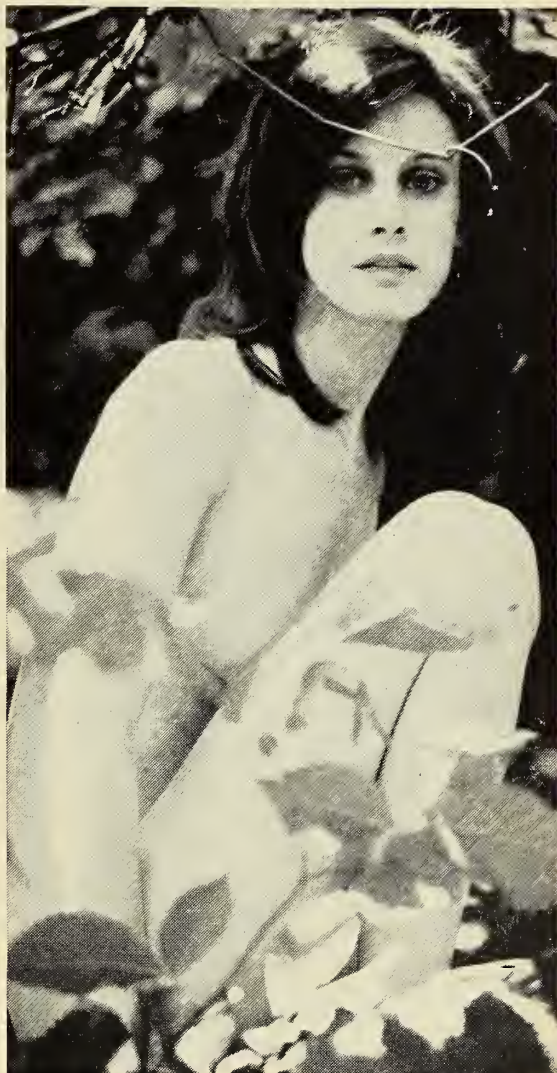
A man or an animal who eats more also welcomes more fat into the bloodstream. The aortic cells take up this fat and multiply, causing lesions which ultimately lead to hardening of the arteries.

Therefore, the more fat on a person, the more cholesterol and lipoproteins in the blood. The blood cholesterol levels usually reflect the amount of low-density lipoproteins circulating, and consequently indicate the probable development of atherosclerosis in arteries.

Once the arteries take up fat, depending on the type and amount, the cells respond by proliferation, injury, or death. The resulting lesions lead to hardening of the arteries.

The University of Chicago researchers are now studying the components of the lipoproteins of animals fed a high fat diet which cause an increase in the growth of aortic cells. According to Dr. Dzoga, cholesterol in serum is an index to the cause, but she asks, "Is it actually the real culprit?"

Skin Saver



Alpha-Keri®

therapeutic bath oil

locks in moisture

relieves dry, itchy skin
with the first bath or shower.

See PDR. Supplied: 8 and 16 fl. oz. bottles; 5 oz. aerosols.

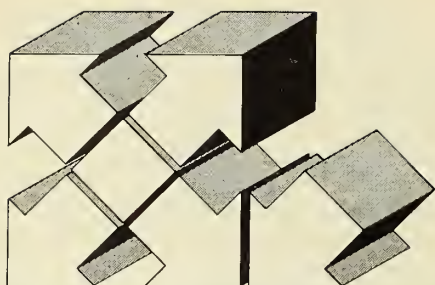
WESTWOOD PHARMACEUTICALS INC. Buffalo, New York 14213

Send samples of Alpha-Keri bath oil.

DR. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ 7



trauma center

EDITED BY LLOYD M. NYHUS, M.D.,
AND DAVID R. BOYD, M.D.C.M.

The management of penetrating wounds of the abdomen with simultaneous bowel and vascular injuries

Lloyd M. Nyhus, M.D.*: We have a fine group with us today to discuss the management of penetrating wounds of the abdomen with simultaneous bowel and vascular injuries. In addition to Dr. Baker, our official discussant, we have Dr. Boyd, who has done much in recent months to develop a Trauma Registry and to activate a realistic trauma program in the State of Illinois. **Steven Holtzman, M.D.:** The case presented today is a 20-year-old male who was admitted to the Emergency Room 30 minutes after sustaining a gunshot wound to the abdomen. On physical examination, the patient was alert and belligerent. His temperature was 99, his pulse was 106, respiration was 20, and his blood pressure 110/90. An entrance wound was present in the right lower quadrant, near McBurney's point, with a wound tract going to the left pelvic wall (Fig. 1). The abdomen was soft, bowel sounds were present; and there were no signs of peritonitis. A 5 x 6 cm hematoma was noted in the region of the left femoral artery. Pulses were diminished but were readily palpable distally. Fifteen minutes after admission, the patient's blood pressure dropped to 60/40 with a pulse of 120. He responded to rapid administration of 1 liter of Dextran and 2 liters of Ringer's lactate. Diagnostic tests were then obtained. The chest film was normal. Abdominal films revealed a normal gas pattern with no free air. The entire abdomen appeared opaque, however, suggesting intraperitoneal fluid. An IVP showed normally functioning kidneys. A cystogram revealed deviation of an intact bladder due to an extrinsic mass.

Following these diagnostic tests, it was noted

that the left groin hematoma had enlarged. The patient was immediately taken to the operating room where he became hypotensive again with a systolic pressure of about 40. An endotracheal tube was inserted and he was given 70% oxygen. He then received 100 grams of albumin followed by rapid type-specific blood replacement. There was no response. The abdomen was subsequently opened through a low midline incision and 3 liters of blood clot was removed. The abdomen was explored and a large retroperitoneal hematoma was found overlying the left iliac vessels. The midsigmoid colon was torn along its anti-mesenteric border. Fecal contamination was present. An umbilical tape was passed around the left common iliac artery for proximal control. Further exploration along the iliac vessels revealed hemorrhage coming from below the inguinal ligament. A groin incision over the left femoral artery was subsequently made and the common femoral artery was found to be transected. With proximal and distal control the blood pressure rose to 110/80. A reverse saphenous vein segment was used to reestablish femoral artery continuity. The abdominal field was then reexamined. A small laceration of the sigmoid was carefully debrided and closed. Stainless steel wire was used for the abdominal wall closure. The skin was left open.

Postoperatively, the patient experienced fever and atelectasis, but was discharged on the twelfth postoperative day.

Dr. Nyhus: Thank you, Dr. Holtzman, for bringing us this very interesting case. Would the surgeon who was present like to comment on some of the minor nuances of the case as he saw it?

W. Stuart Battle, M.D.: This man was acutely ill and it was obvious that he would not be able

*Warren H. Cole Professor and Head, Department of Surgery, The Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, Chicago.

to restore his intravascular volume rapidly enough to prevent his demise. So, after a suitable time of rapid transfusion on the operating table, the decision was made to open the abdomen and attempt to do this. Upon opening the abdominal cavity, we were greeted with about 3 liters of clotted and non-clotted blood, which was evacuated. The large retroperitoneal hematoma was noted overlying the left iliac vessels. There was a laceration in the retroperitoneum at this point, through which a large amount of bright red blood was coming. Dissection was carried out around the proximal left common iliac artery and tapes were passed and proximal control gained. We noted at this time that there was a hole in the sigmoid colon with fecal contents issuing forth. We immediately packed this off and closed it temporarily to prevent further contamination of the peritoneal cavity. The field was covered with a steridrape; we changed gloves and gowns and made an additional further incision in the groin over the femoral vessels. We found the transection of the common femoral artery just below the inguinal ligament about 1 cm proximal to the takeoff of the profunda femoris artery. The vessels were mobilized down into the thigh, but we could not obtain primary reapproximation without a great deal of tension. Therefore, we took a saphenous vein segment from the same leg, reversed it, sewed it in place and bridged the gap. We then closed this wound carefully in layers, covered it with a dressing, and then redirected our attention to the abdomen and the sigmoid colon problem.

Dr. Nyhus: In order to highlight our discussant's points, I would like to ask you about your decision to close a gunshot wound of the sigmoid colon, how you did it, why you did it. War experience suggests the we should never close one of these but should do exteriorization, or at least a proximal colostomy. However, in civilian practice, it has been shown, particularly in New Orleans, that possibly in the civilian population, the non-battlefield type, you may get away with closure. I would like to know why you made this particular decision in this particular instance. Another point I would like you to speak to is, as I understand it, you incised into this patient's abdomen when he had no blood pressure. Is that correct?

Dr. Battle: Correct.

Dr. Nyhus: I appreciate the fact that you resuscitated the patient on the operating table. I assume that you had prepared his abdomen while you were resuscitating him. Is that correct?

Dr. Battle: Exactly.

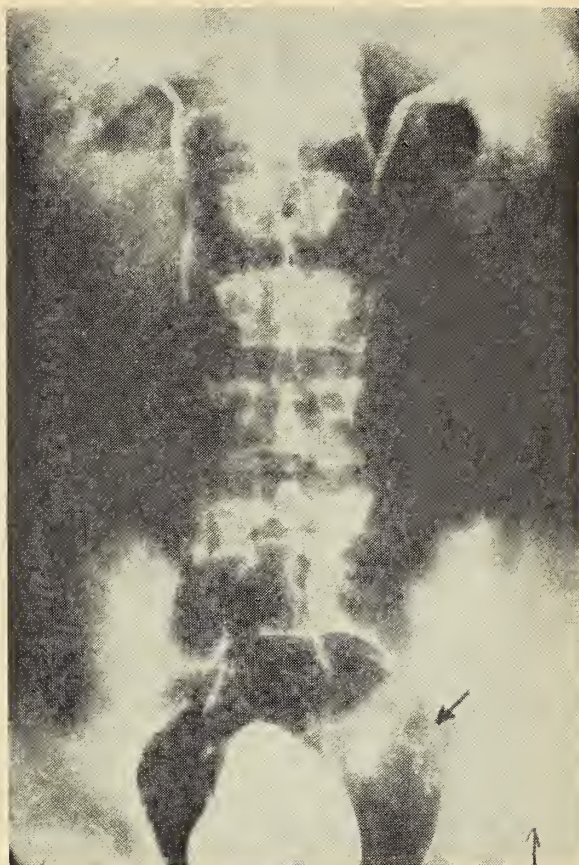


Fig. 1. Flat plate of abdomen showing IVP, cystogram, and trajectory of bullet.

Dr. Nyhus: We know from hindsight that he had a hematoma—I am sure he bled when you evacuated the hematoma; he probably wasn't losing large amounts of blood at the time that you made your incision. The question is: Why didn't you have three large bore catheters in position for rapid and effective resuscitation before making your incision? We know the increased risk when proceeding with operation in the face of profound shock. Would you comment on these two points?

Dr. Battle: With reference to your first point, an exteriorization procedure was considered. The technic of primary closure with proximal diverting colostomy was considered. The gunshot wound in the colon was extremely small.

Dr. Nyhus: Was it pinpoint?

Dr. Battle: It was about 2 mm in size.

Dr. Nyhus: So you made the decision to close the defect primarily without a diverting colostomy on the basis of the smallness of the hole.

Dr. Battle: Exactly. It was possible to excise the damaged colon completely and close it primarily with no risk of leaving nonviable tissue.

Dr. Nyhus: It will be very interesting to hear

Penetrating wounds

what our discussant has to say about this decision. Now, about the other problem.

Dr. Battle: As I mentioned earlier, we were resuscitating him on the operating table. The time which had passed from entering the Emergency Room until the time we had him on the operating table was about 45 minutes. He had stabilized in the Emergency Room long enough to obtain diagnostic studies but on the way to the operating room he decompensated again. After about 30 minutes of trying to resuscitate him on the operating table with two large bore catheters in the upper extremities and pumping cross-matched type specific blood as fast as possible, we were still not gaining ground. His blood pressure was not responding; his peripheral circulation remained poor and it became apparent that he was losing blood faster than we could put it in, and the only way to control the situation was to stop the egress of blood.

Dr. Nyhus: Thank you very much, Dr. Battle. Dr. Baker, would you take it from here and make the cogent points? I am going to ask Dr. Boyd to also comment a bit later.

Robert J. Baker, M.D.*: Probably no area of surgery is as uniformly mishandled throughout the country as trauma. Although there are a number of areas in which serious question about the appropriate treatment in any given case arises, I think that the area of colon injuries is one in which the facts are now becoming known. I refer to publications of the past three or four years, which have largely refuted the claim that in civilian practice any penetrating wound of the colon can be closed and dropped back without increasing the morbidity and mortality rates.

Let me point out one or two interesting features about colon trauma. When we talk about colon trauma, what we really are talking about is two types of wounds with regard to the anatomical location of the wound. Trauma to the right side of the colon includes injuries in which the blood supply to the colon is not as good as it is on the opposite side. But, more important, the content of the bowel is liquid on the right and solid on the left. Therefore, one could make a case for a more "aggressive" attitude towards wounds of the right colon. If you are ever going to be able to "get away" with primary closure of a colon gunshot, or even a stab wound, the place where success could be anticipated would be where the colon is of larger caliber and the con-

tent is liquid, thereby having less abrasive action as the stool begins to progress across the suture line when peristalsis returns. Dr. Boyd reviewed about 75 colon injuries limited to the right colon. He found that in those patients in whom we were injudicious enough to close the wound and drop it back into the abdomen, we had exactly twice as many complications as we did when the colon was exteriorized.¹

The primary complication is wound infection, which is an annoyance and potentially a hazard in terms of evisceration or dehiscence of the wound. Another, even greater hazard is intra-abdominal abscess when colon leakage occurs. Fistula is an unusual, but definite third complication. In patients with the most innocuous wound, that is, the stab wound of the right colon, we performed primary closure and had exactly twice the number of complications of wound infections and abscesses, as in those with exteriorized colon wounds. Exteriorization of the bowel or resection and proximal diversion still remain, judging by the data we have gathered over the last six or eight years, the best treatment for all colon wounds.

I feel keenly that the size of the hole has no significance; I do not think you can judge what is going to happen to a leaking colon wound because it happens to be 2 mm or 2 cm. There are too many other factors involved. I would like to dismiss colon wounds by saying that unless it is technically impossible to divert proximally or to repair and exteriorize, it is essential that resection of that part of the colon which is injured be done. Colon wounds must be handled appropriately, which means exteriorization and/or proximal diversion, depending on the location of the injury.

This patient was brought into the Emergency Room with a hematoma in the groin and a gunshot wound which traversed the abdomen from one flank to the other thigh. The hematoma in the left groin should have been an absolute clue to the presence of vascular injury. There are certain things that make us suspect arterial injury. The absence of distal pulses is very important. The second hallmark of arterial injury is a pulsating mass with or without a bruit. As in this case, about three quarters of these patients will have a distal pulse. There are also some rather subtle findings: coolness of the distal extremity and hypesthesia. The patient who has a gunshot or stab wound in which there is no bleeding, but sudden bleeding from the wound occurs, or there is recurrent bleeding from a penetrating wound, should always make one suspicious of significant arterial injury.

*Professor of Surgery, The Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, Chicago.

If you couple that with the patient's course in the Emergency Room, that is, 15 minutes after admission, the blood pressure suddenly dropped and the pulse rate increased, secondary arterial hemorrhage should have been considered. The patient was taken to the X-ray Department, with evidence that he had bleeding from an injured artery. In this patient, with his vascular instability, this was not the optimal approach. The most I would have done with this patient would have been to start a drip of about 100cc of 50% diatrizoate (Hypaque) in a liter of fluid, and performed a portable abdominal film on the operating table just before I made the incision. This infusion pyelogram would demonstrate the presence of two functioning kidneys, a potentially valuable bit of information.

When he arrived in the operating room, he was seriously hypotensive. This brings up the point of the use of type specific or uncross-matched whole blood. It has been suggested that uncross-matched whole blood is perfectly satisfactory. This is absolutely untrue. There is a very serious problem with uncross-matched whole blood and that is the problem of subgroup sensitivity. People have died who have been given uncross-matched whole blood despite the fact that the blood they received was 0, Rh negative. This does not take into consideration the 55 or more subgroups. It is definitely hazardous to use uncross-matched whole blood.

Many investigators have shown that the use of whole blood is vastly overrated, that you can expand vascular volume with colloid or crystalloid, especially crystalloid, very easily and keep the patient alive for anywhere from 30 to 60 minutes. If the hematocrit isn't pushed below 25%, the chances are that the normal myocardium will handle this dilution reasonably well. I would suggest that rather than use uncross-matched whole blood, get a quick cross-match and rely on serum albumin, Dextran, or Ringer's lactate in the interim.

The most knotty issue in this case is that of the patient who has fecal contamination of the peritoneal cavity in communication with vascular injury. It is probably one of the hardest of all problems in trauma to solve. World War II taught that arterial repair of major arteries in the face of penetrating wounds of the colon were associated with a 50-60% leak rate and a mortality rate which was about two-thirds of that. It has become apparent that when an artery is sectioned by a bullet, you don't just sew it back together. It must be debrided back to healthy artery, precisely what was done in this case. I think

the arterial repair in this case was faultless.

As a rule, you can bridge up to a 3 cm defect with mobilization and do an end-to-end repair. Two of the exceptions to the rule, however, are the common femoral artery, and the common iliac artery, which are very hard to mobilize, and in which adequate repair is of extreme importance. If an artery is closed under tension, it will either leak, or it will stenose and thrombose. Doctor Battle did debride the vessel, and was then faced with the decision about how he was going to bridge the defect. He had two avenues of attack open to him. The first was to use a prosthesis such as dacron. Placement of a prosthesis in this contaminated wound carries with it a very high risk of infection, leak, and subsequent limb loss. As a basic rule, a prosthesis should not be used in a contaminated wound.

The second choice is how I personally would have solved the problem—in exactly the same way as did Doctor Battle. The saphenous vein is removed from the groin, turned end for end so that the valves will not obstruct flow. From then on it becomes a problem of meticulous wound closure. I don't know what antibiotic was used in this patient, but I would certainly have used one of several broad spectrum antibiotics. Which one did you use, Dr. Battle?

Dr. Battle: Keflin and kanamycin.

Dr. Baker: Keflin and kanamycin are the usual ones that we use for coliforms, because it turns out that the most serious organisms in colon wounds are the microaerophilic and anaerobic organisms. These are the most troublesome, as they are the hardest to handle, and very difficult to isolate in the laboratory. The choice of the antibiotics here was good and I would certainly use intravenous antibiotics for seven to ten days. Some would have combined this with methicillin, looking for an anti-Staphylococcal agent.

Dr. Nyhus: Thank you, Dr. Baker. Dr. Levitsky, would you make a few cogent points, from your Vietnam experience on colon and vascular trauma?

Sidney Levitsky, M.D.*: I agree with most of the things that Dr. Baker has said, except for a few minor points. First, I think this patient should have had a CVP cannula inserted immediately upon arrival to the Emergency Room. That would have told you immediately whether you're behind or not in replacing the intravascular volume. If he dropped his blood pressure down to 60/40, and had a very low CVP, I would

*Associate Professor of Surgery, The Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, Chicago.

Penetrating wounds

have filled up the intravascular space before I moved him to X-ray. I would not be reluctant to administer 4 or 5 liters of fluid to this young, healthy man.

Dr. Nyhus: What fluid would you have used?

Dr. Levitsky: Ringer's lactate, but I don't think it makes much difference. I disagree with Dr. Baker about the low titer 0 negative blood. He and I have discussed this several times. His point is well taken. But when a patient is massively bleeding, he's bleeding blood, he's not bleeding plasma, and he is not bleeding Dextran. Sometimes you just have to get the patient to the operating room to get his abdomen open to control massive hemorrhage.

We have a large experience with low titer 0 negative blood. Obviously, under military conditions we didn't follow each patient for a prolonged period. But in the large series that the military have followed, they found the incidence of transfusion reactions of young, healthy males very low when using low titer 0 negative blood. Admittedly these patients later on may get into problems. Jaundice occurred in about 20% of the patients I saw. But as far as renal shutdown and mortality associated with the use of low titer 0 negative blood, it was minimal.

As far as the colon injury, I agree completely. Because of the vascular injury, I wouldn't waste time dealing with the colon except to exteriorize it at the point of injury as a loop colostomy.

As far as the arterial surgery is concerned, I think you did exactly the right procedure. It's poor surgery when patients leave the operating room with their knee up under their chin because the surgeon tried to do a primary anastomosis under tension. This has been done in some instances and has led to thrombosis. In our Vietnam vascular series, we used a primary anastomosis or a vein graft.²

Dr. Nyhus: Excuse me, I just want to be sure that we've got it straight. About prostheses and infected wounds . . .

Dr. Levitsky: I never use vascular prostheses in an infected wound. LTC Norman Rich (Vietnam Vascular Registry) has extensively reviewed all the vascular injuries in the Vietnam series (over 1400 are listed in the registry), and he has come up with some very interesting data which substantiates these principles.

Dr. Nyhus: Thank you, Dr. Levitsky. Dr. Boyd, do you have some points that you could give us?

Dr. David R. Boyd: I agree with the other two discussants in that the need for immediate lap-

arotomy in the patient who is resuscitated and then fades away, is apparent. The CVP is very helpful in this regard. We have seen two or three good examples here of vascular and colon trauma where the use of data collection systems such as registries can be helpful.^{3,4} Our Trauma Registry has started to pay off for us. The primary repairs in our right colon series that Dr. Baker mentioned were a great surprise to us.

To be specific about these right colon injuries, we had 24 that were primarily repaired which had a 41% wound infection rate, and 41% had pelvic abscesses that had to be surgically drained. In those 27 colon injuries that were exteriorized, there was only a 23% wound infection and absolutely *no* pelvic abscesses. Using a tube cecostomy for injuries of the cecum, we had a 33% wound and a 33% abscess rate. However, we were not using the largest tube available and this may point to a technical problem. We have, by virtue of the Registry, evaluated some 392 colon injuries which were separated into right, transverse, left, and rectal injuries. From this series, it again appears that exteriorization or some form of colonic decompression is the best method of treatment.

Dr. Nyhus: We have reviewed the problem of a complicated gunshot wound of the abdomen with colon and major arterial injury. The fine nuances of diagnosis and resuscitation have been mentioned. The life-threatening arterial injury must be controlled as soon as possible with primary repair of the defect or insertion of a vein graft (contaminated wound). In general there is agreement that colon wounds should be exteriorized, or proximally vented and resected when massively damaged. Primary repair of the colon wound (trauma) is fraught with a high incidence of wound infection, intraperitoneal abscess, and indeed, death.

References

1. Chilimindris, C., Boyd, D. R., Carlson, L. E., Folk, F. A., Baker, R. J., and Freeark, R. J.: "A critical review of management of right colon injuries," *J. Trauma*, 11:651-660, 1971.
2. Levitsky, S., James, P. M., Anderson, R. W., and Hardaway, R. M.: "Vascular trauma in Vietnam battle casualties: an analysis of 55 consecutive cases," *Ann. Surg.*, 168:831-836, 1968.
3. Rich, N. and Hughes, C. W.: "Vietnam vascular registry: a preliminary report," *Surg.*, 65:218-226, 1969.
4. Boyd, D. R., Rappaport, D. M., Marbarger, J. P., Baker, R. J., and Nyhus, L. M.: "Computerized trauma registry: a new method for categorizing physical injuries," *Aero. Med.*, 42:607-615, 1971.

Learn the new J C A H
****Accreditation Standards**
****Guidelines for Medical Staff Bylaws**
at
a Joint Commission on
Accreditation of Hospitals
Workshops

Thursday & Friday
April 6 & 7, 1972
Ramada Inn, Champaign

or

Wednesday & Thursday
April 12 & 13, 1972
LaSalle Hotel, Chicago

Each Workshop includes:

First Day . . . *

**New Rules for Governing Body &
Management . . . Medical Staff
. . . Medical Record Requirements
. . . Hospital Construction**

Guidelines for Medical Staff Bylaws

Second Day . . .

**Physician Services

Nursing, Pharmacy &
Environmental Services**

Medical Record Services

***Note:** Most staff physicians need attend only the first day. However, pathology and radiology-nuclear medicine standards are part of second-day program.

**Co-Sponsors: Illinois State Medical Society
Illinois Hospital Association**

**For details contact: PR Division, Illinois State Medical Society
360 N. Michigan Ave., Chicago 60601
312-782-1654**

28th MIDWEST CLINICAL CONFERENCE — CMS &
132nd ANNUAL MEETING OF THE ISMS
MARCH 8-11, 1972

CONRAD HILTON — CHICAGO, ILLINOIS

Name
Confirm to (Address)
City State Zip
Arr. Date Hour a. (p.) m. Dep. Date

PLEASE CIRCLE RATE REQUESTED

	MINIMUM	AVERAGE	SUPERIOR
Singles	\$18*-21*	\$23-25-27	\$29-31-33
Doubles			
& Twins	\$33-35	\$37-39	\$41-43
Deluxe Twins	\$45 (Single or Double Occupancy)		
Suites \$57.00 & up	*Single bedded rooms.		

THE CONRAD HILTON TOWERS

Singles	\$30-33 & up
Doubles	
& Twins	\$40-43 & up
Deluxe Twins	\$50-53
Suites available	on request

If rate requested is not available, next available rate will be confirmed.
Rooms will be held until 6 p.m. on the date of arrival unless we are otherwise advised.
Room reservations must be received 15 days prior to opening of convention.
Rates do not include applicable Sales, Occupational or other taxes.

APPROVED

AVAILABLE NOW!
ISMS
MALPRACTICE INSURANCE

Professional Liability Insurance
Program
Approved for Members
REGARDLESS of AGE
or SPECIALTY

Protect Doctor's Integrity

Company will settle no claims without insured member's approval. Nuisance claims will be fought.

Improve Legal Climate

Company will retain outstanding defense counsels who are experts in professional-liability cases.

Provide Market Stability

Company will maintain an available market. Participation by the members is needed to assure this market.

Keep Members Informed

Company will tell members how to prevent claims . . . keep them aware of latest legal developments in malpractice field.

ISMS Supervision And Control

Premiums to reflect only the loss experience of ISMS. All questionable underwriting cases to be reviewed by ISMS. A UNIQUE FEATURE

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT ADMINISTRATORS:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000



socio-economic news

By JOSEPH J. LOTHARIUS

M.D.s named to state HASP Committee

Four physicians have been named to the state HASP (Hospital Admissions and Surveillance Program) Committee by the Illinois FMC. They are Drs. Frank J. Jirka, Jr., River Forest; Eugene P. Johnson, Casey; Fred A. Tworoger, Chicago; and Fred Z. White, Chillicothe. The consumer representative on the seven member state HASP Committee is Lester Munson, Jr., Chicago, who was appointed by the Illinois Department of Public Health. Still to be named are two hospital representatives. The state HASP Committee will make policy decisions for the program which will certify the length of hospital stays for all Medicaid patients. HASP became operational on January 17 in seven Chicago hospitals which had the largest number of Medicaid patient days. The program will be expanded and eventually cover every hospital in the state.

MDs must make fee Data available

Physicians must make fee information available to their patients and can increase their fees only 2.5% according to the Wage-Price Stabilization Board. The Board says a sign must be posted in a prominent location (such as the reception room) advising patients that the fee information is available upon request. The price list must include fees charged prior to August 14, 1971, for those services that account for 50% of the physician's dollar volume.

ISMS executive named To new licensure commission

Roger N. White, ISMS Executive Administrator, was named as one of the eight public members of the new Health Care Licensure Commission. The other public members include: David M. Kinzer, Chicago, executive vice president of the Illinois Hospital Association; H. Martin Engle, M.D., Chicago, vice chancellor of the University of Illinois medical school; Richard C. John, Rock Island, Tri-City Building Trades Council; Miss Cristine Allen, R.N., Chicago, Malcolm X College; Floyd Curl, Neoga, vice-chairman, Board of Trustees, Lakeland Junior College; Eugene Hoffman, Chicago chiropractor, and James Bailey, Rockford businessman. The appointments, made by Governor Ogilvie, established the Commission which was authorized under H-854 passed during the recent legislative session. The Commission will examine, review and recommend changes for all state statutes regarding the licensure of health care personnel. The composition of the Commission also includes 12 legislators in addition to the eight public members.

IDPA invites MD criticism

Physicians will have a chance to express their views about the Illinois Department of Public Aid through its Medical Advisory Committee whose functions and responsibilities have been expanded. Future Committee meetings will be held in different areas of the state. All county medical societies within the respective trustee districts will be invited to attend. IDPA has given its assurance that the Medical Advisory Committee will address itself to major issues facing the Department. The Committee's recommendations on these issues will go to the Governor and influence his policy decisions. The Committee will also continue to function as a review body on specific cases. IDPA will send invitations to all appropriate county medical societies before each meeting.

Clinical courses to be offered at convention

SURGERY INSTRUCTIONAL COURSE **March 8, 1972**

1st Session—Presiding Officer:

Dr. Herbert Greenlee

9:00 a.m. **"Ascending Cholangitis—An Urgent Surgical Problem"**

Dr. James Mason

9:30 a.m. **"Surgery for Chronic Pancreatitis"**

Dr. Herbert Greenlee

10:00 a.m. Intermission

2nd Session—Presiding Officer: Dr. Paul Fox

11:00 a.m. **"Newer Techniques in Burn Care"**

Dr. Nelson Stone

11:30 a.m. **"Abdominal Masses in Infancy and Childhood"**

Dr. Paul Fox

3rd Session—Presiding Officer: Dr. John Saletta

1:30 p.m. **"Surgical Management of Inflammatory Bowel Disease"**

Dr. George Block

2:00 p.m. **"Peptic Esophagitis"**

Dr. E. Thomas Bombeck

2:30 p.m. **"Soft Tissue Injuries to the Neck"**

Dr. John Saletta

3:00 p.m. Intermission

4th Session—Presiding Officer:

Dr. Steven Economou

4:00 p.m. **"Radiologic Diagnosis of the Acute Abdomen"**

Dr. Leon Love

4:30 p.m. **"Role of the Surgeon in Hodgkin's Disease"**

Dr. Steven Economou

OBSTETRICS AND GYNECOLOGY **March 9, 1972**

Presiding: John J. Barton, M.D.

9:00 a.m. **"Cytogenetics"**

Albert Gerbie, M.D.

9:30 a.m. **"Post-menopausal Bleeding"**

John I. Brewer, M.D.

10:00 a.m. Intermission

11:00 a.m. Panel: **"Medical Complications of Pregnancy"**

Moderator: *Fred Tworoger, M.D.*

Sheldon Waldstein, M.D.: Thyroid Disorders

S. Berger, M.D.: Management of Diabetes in Pregnancy

L. Shewitz, M.D.: Hypertension Disorders in Pregnancy

12:00 a.m. Lunch

Presiding: *Ralph Wynn, M.D.*

1:30 p.m. Panel: **"What's New in Obstetrics and Gynecology?"**

Moderator: *Sidney C. Kahn, M.D.*

L. Hamilton, M.D.: Fetal Monitoring

J. Daskal, M.D.: Laparoscopy

J. Barton, M.D.: Cryosurgery

E. Savage, M.D.: Cuposcopy

2:30 p.m. **"Gonorrhea in the Female"**

Edwin De Costa, M.D.

3:00 p.m. Intermission

4:00 p.m. Panel: **"Current Concepts on the Management of Gynecological Malignancy"**

Moderator: *Ronald R. Greene, M.D.*

Jack Isaacs, M.D.: Surgical Management of the Cervix

Mel Gerbie, M.D.: Surgical Management of the Vulva

Theodore Eckman, M.D.: Chemotherapy

Eugene Lutterbeck, M.D.: Radiotherapy

MEDICINE INSTRUCTIONAL COURSE

NO. III

March 10, 1972

9:00 a.m. Panel Discussion—"What's New in Chronic Pulmonary Disease"

Whitney Addington, M.D.

James R. Webster, M.D.

Douglas R. Gracey, M.D.

Ronald A. Smerdjian, M.D.

10:00 a.m. Intermission for Review of Exhibits

11:00 a.m. **"What's New in Hematology"**

Wilson H. Hartz, M.D.

11:30 a.m. **"What's New in Coronary Care"**

Richard Davison, M.D.

1:30 p.m. **"What's New in Diabetes and Pregnancy"**

Norbert Freinkel, M.D.

2:00 p.m. **"New Concepts in Hypertension and Pregnancy"**

Norman M. Simon, M.D.

2:30 p.m. To be announced

3:00 p.m. Intermission for Review of Exhibits

4:00 p.m. **"What's New in Gastroenterology"**

Howard Schachter, M.D.

4:30 p.m. **"New Concepts in the Diagnosis and Management of Venereal Disease"**

Boris E. Reisberg, M.D.

PEDIATRICS INSTRUCTIONAL COURSE

March 11, 1972

(A 10-minute question and answer period will follow each topic presentation.)

9:00 a.m. **"Catecholamine Metabolism in Neuroblastoma and Pheochromocytoma"**

Ira Rosenthal, M.D.

9:30 a.m. **"Amniocentesis and its Application for Genetic Counseling"**

Serge Melancon, M.D.

10:00 a.m. Intermission

11:00 a.m. **"Sickle Cell Anemia, Crises and Treatment"**

Ruth Seeler, M.D.

11:30 a.m. **"Rheumatic Fever Prophylaxis"**

Burton Grossman, M.D.

12:00 a.m. Lunch

1:30 p.m. **"Inborn Errors of Amino-Acid**

Metabolism"

Paul Wong, M.D.

2:00 p.m. **"The Battered Child"**

Rowine Hayes Brown, M.D.

2:30 p.m. **"Cardiac Emergencies in Children"**

Juan P. Bicoiff, M.D.

3:00 p.m. **"Phenylketonuria and Hyperphenylalaninemia"**

David Y. Hsia, M.D.

3:30 p.m. **"Nephrotic Syndrome in Children"**

Aaron Grossman, M.D.

4:00 p.m. **"Emerging Problem of Megaloblastosis"**

Wayne Borges, M.D.

4:30 p.m. **"Intrauterine Growth Problems"**

Rosita Pildes, M.D.



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed.

Duplicate Single Products

NITRO-BID

Plateau Caps Vasodilators-coronary R

Manufacturer: Marion

Nonproprietary name: Nitroglycerin

Indications: For prophylactic management of angina pectoris

Contraindication: Recent myocardial infarction, severe anemia, glaucoma, hypotension and idiosyncrasy to drug

Warning: Capsules must be swallowed. For oral not sublingual use.

Dosage: One capsule two or three times daily at 8 and 12 hr. intervals

Supplied: Capsules, 2.5 mg. and 6.5 mg.

TRITEN Antihistamine

R

Manufacturer: Marion

Nonproprietary name: Dimethindene maleate

Indications: Wide range of allergic and pruritic disorders

Precautions: Caution patients about activities requiring alertness, as antihistamines often produce drowsiness

Dosage: Adults and children over 6 years of age—one to two 1 mg. tablets one to three times daily, one 2.5 mg. TAB-IN once or twice daily.

Supplied: Tablets, 1 mg.

TAB-IN, 2.5 mg.

Combination Products

FIOGESIC Analgesic

R

Manufacturer: Sandoz

Composition: Each tablet contains

Calcium carbaspirin	382 mg.
(equivalent to 300 mg. aspirin)	
Phenylpropanolamine HCl	25 mg.
Pheniramine maleate	12.5 mg.
Pyrilamine maleate	12.5 mg.

Indications: Temporary relief of headache, sinus and nasal decongestion, pain and fever due to sinusitis, common cold or influenza.

Precautions: Not for children under 6 years old. Individuals with high blood pressure, heart disease, thyroid disease should use only as directed by physician.

Dosage: Adults—two tablets followed by one or two tablets every four hours, up to six per day.

Children (6 to 12 yrs.)—one-half to one tablet every four hours up to four tablets per day.

Supplied: Tablets

Hexachlorophene and newborns

A number of recent studies have raised serious questions concerning the toxicity of hexachlorophene preparations used for total body bathing of newborn infants. Hexachlorophene has been claimed as an effective prophylaxis against nursery epidemics of staphylococcal skin infections. A critical review of this claim has shown *there*

is a lack of substantial evidence that hexachlorophene washings by themselves prevent staphylococcal disease or show antibacterial activity against gram-negative organisms.

The FDA and Committee on Fetus and Newborn of the American Academy of Pediatrics have jointly concluded that *the use of hexachlorophene for total body bathing of infants in hospital nurseries or at home is not recommended.* In its place the committee recommends: dry skin care and washing with plain soap and

water or tap water alone for skin care of the newborn infants.

The labeling of 3% hexachlorophene products is being amended to advise against their use for total body bathing.

The effectiveness of 3% hexachlorophene for other uses has been studied by the Food and Drug Administration and the National Academy of Sciences. On December 8, 1971, FDA published NAS Drug Efficacy Study evaluations rating such products effective for use as bacteriostatic skin cleanser (including surgical scrub). They are rated possibly effective* for use in the treatment of impetigo in newborns and of other staphylococcal skin infections, and in the treat-

ment of cradle cap and in helping to clear acne. They are found to be lacking in substantial evidence of effectiveness for use in the relief of pruritus ani, for the broad claim as a vaginal douche, in the treatment of chronic eczema, in irrigating or cleansing wounds and burns, and as an "aid to personal hygiene."

Further studies will be necessary to determine the ultimate usefulness of hexachlorophene preparations.

**A rating of possibly effective means that there is little evidence of effectiveness for the given indication. Substantial evidence of the effectiveness of drugs is required by law. The responsibility for substantial evidence of effectiveness of a drug rests with the manufacturer.*

Diethylstilbestrol linked to adenocarcinoma in offspring

We wish to bring to the attention of all physicians, hospitals, and medical personnel an important possible toxic effect of diethylstilbestrol reported for the first time in April 1971, by Herbst, et al.¹ From their studies the authors concluded that *maternal ingestion of diethylstilbestrol during pregnancy appears to increase the risk of vaginal adenocarcinoma developing years later in the offspring exposed*. The authors studied eight cases of adenocarcinoma of the vagina in patients born between 1946 and 1951. The malignancies were identified and treated between 1966 and 1969. In seven of the eight cases, there was a history of maternal use of diethylstilbestrol. Because this type of malignancy in young girls had rarely been reported previously the authors conducted a retrospective investigation in an attempt to find factors that may be associated with such malignancy in this age group. Four matched controls were established for each patient and the data obtained were subjected to statistical analysis. A statistically significant relationship was observed for three variables: diethylstilbestrol given during pregnancy ($p=.00001$), bleeding in that pregnancy ($p=\text{less than } .05$) and prior pregnancy loss ($p=\text{less than } .01$). It is obvious that the most significant of the variables is the administration of diethylstilbestrol during pregnancy.

Since publication of this study, five additional cases of this malignancy associated with the maternal use of diethylstilbestrol have been re-

ported by Greenwald, et al.² Dr. Herbst, in a recent communication to FDA, has reported an additional 15 cases associated with use of this drug, bringing the total number of known cases to 27. It must be emphasized that this type of epidemiologic study defines only an association and not necessarily a cause-and-effect relationship. Further studies are underway to clarify the significance of these findings.

Both FDA and the medical profession face a responsibility to help determine whether this reported association constitutes a cause-and-effect relationship. We ask that all physicians consider appropriate steps to assist FDA case-finding and to protect any patients who might be at risk.

It may be possible to trace the offspring of those mothers who received DES during pregnancy. All physicians should be especially alert for young women whose mothers may have received hormonal therapy during pregnancy, particularly those young women who may be experiencing irregular vaginal bleeding. The association should be a routine consideration for physicians whose practice includes young women.

This is a previously unsuspected health problem. Further information is essential to the FDA and to the medical profession. We ask your help in reporting any cases you encounter for entry in a case registry.

References

1. Herbst, et al: "Adenocarcinoma of the Vagina" *New Eng. J. of Med.*, 284:16 (April 22, 1971).
2. Greenwald, et al: "Vaginal Cancer After Maternal Treatment with Synthetic Estrogens," *New Eng. J. of Med.*, 285:7, (August 12, 1971).

what goes on

a guide to continuing education

February 19-20—American Society of Anesthesiologists

"ASA Workshop on Electrocardiography for the Practicing Anesthesiologist"

Sheraton Four Ambassadors Hotel, Miami, Fla.

February 19-22—American Society of Anesthesiologists

"17th Annual Postgraduate Anesthesiology Course"

For information write: American Society of Anesthesiologists, 515 Bussee Highway, Park Ridge, Ill. 60068.

University of Utah College of Medicine, Park City, Utah

February 23-24—American College of Emergency Physicians

"Community Emergency Medical Services and the Management and Design of Emergency Departments"

This symposium will include: Architecture of the ED; ED Physician Education; ED Policies and Procedures; ED Staffing and Patterns; EMS Councils; EMS Transportation and Communications; EMT Courses and Laws; Funding the ED; Government Funding for EMS; Hospital Administrator/ED Physician Dialogue; Profession ED Personnel and X-Ray Department Relations. For information and registration write: American College of Emergency Physicians, 241 E. Saginaw St., East Lansing, Mich. 48823.

February 27-March 1—American Fertility Society

"5th Postgraduate Course and 28th Annual Scientific Meeting"

The Postgraduate Course will consist of eight seminars and three workshops at area hospitals. Among topics at the Annual Meeting will be Ovarian Function; The Oviduct, Hypothalamic-Pituitary Function; Immunology; The Male Factor; Population Trends; Fertility Control; Abortion and Sterilization; and Endoscopy. For information and registration contact: Herbert H. Thomas, M.D., Medical Director, American Fertility Society, 1801 9th Ave., South, Suite 101, Birmingham, Ala. 35205.

Waldorf Astoria Hotel, New York City, N.Y.

February 27-March 3—American Academy of Facial Plastic and Reconstructive Surgery, Inc.

"Workshop in Advanced Rhinoplasty"

For experienced surgeons who already perform this procedure but seek additional instruction at an advanced level. Registration \$500. For information write: Dr. William K. Wright, Director, Suite 508, Herman Professional Bldg., Texas Medical Center, Houston, Texas 77025.

Baylor University College of Medicine, Houston, Tex.

February 27-March 4—Society for Contemporary Ophthalmology

"Annual Meeting"

All ophthalmologists and other physicians interested in contemporary ophthalmology are invited to attend. For further information write: Secretary, American Society of Contemporary Ophthalmology, 30 N. Michigan Ave., Chicago, Ill. 60602.

Diplomat Hotel, Hollywood, Fla.

February 28-March 3—New York University Post-Graduate Medical School

"Symposium on Arthritis"

A panel of distinguished lecturers composed of faculty members of the NYC School of Medicine and a number of other medical schools will present recent information about these disorders and analyze current thought about basic disease mechanisms and treatment approaches. Fee \$150. For registration and information write: Office of the Recorder, New York University Post-Graduate Medical School, 550 1st Ave., New York, N.Y. 10016.

550 1st Ave., Manhattan, N.Y.

March 1—University of Chicago, Eye Research Laboratory

"Annual Alumni Day"

A buffet luncheon beginning at 11:30 a.m. will precede the scientific program. All ophthalmologists are invited to attend. There are no fees. For information write: J. Terry Ernest, M.D., assistant professor of ophthalmology, University of Chicago, The Eye Research Laboratory, 950 E. 59th St., Chicago, Ill. 60637.

Albert Merritt Billings Hospital, Chicago

March 1-4—University of Miami Law Center and School of Medicine

"Medical Malpractice a Legal Course for Doctors"

The purpose of this seminar is to give the doctors and hospital administrators an in-depth introduction to their legal rights and duties in relation to their patients. Taught completely by lawyers, it will be a non-adversary, factual, legal and practical presentation for the purpose of education. Inquiries write: IV/Medical/Legal Institute, University of Miami Law Center, PO Box 8087, Coral Gables, Fla. 33124.

Americana Hotel, Bal Harbour, Fla.

March 1-5—American College of Cardiology

"21st Annual Scientific Session"

Among scientific program highlights will be clinics at Chicago medical centers and hospitals, a Core Curriculum program, a "Controversies in Cardiology" discussion, fireside conferences and informal luncheon panels and master teacher seminars. For information write: William D. Nelligan, Executive Director, American College of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014.

Chicago

March 4—Alfred Adler Institute

"Teacher-Parent and Family Group Consultation"

(See March 25-26 listing)

March 8-9—University of Missouri-Columbia School of Medicine

"Conference on Diabetes Mellitus"

During the conference knowledge regarding the primary lesion in diabetes and the pathogenesis of the devastating microangiopathy will be reviewed in concise presentation by authorities in the field. Problems in the management of acute complications, including hypoglycemia, ketoacidosis and lactic acidosis, and hyperticalosmolar coma are to be covered. For information write: University of Missouri-Columbia, School of Medicine, Committee for Continuing Medical Education, M-175 Medical Ctr., Columbia, Missouri 65201.

March 10-11—Kramer Foundation

"Therapeutic Community"

"From Theory to Practice"

For information write: Dr. Leon Schwartz, Coordinator, Kramer Foundation, 2 W. Johnson Street, Palatine, Ill. 60067.

Plum Grove Nursing Home, Palatine, Ill.

March 11-12—American Society of Anesthesiologists

"17th Annual Postgraduate Assembly"

Los Angeles County Society of Anesthesiologists, Los Angeles, Calif.

March 12-16—International Anesthesia Research Society

"46th Congress"

Caesars Palace-Las Vegas, Nev.

March 13-15—American College of Surgeons

"Joint Meeting for Doctors & Nurses"

In addition to general surgery, there will be programs in ten surgical specialties: gynecology and obstetrics, neurosurgery, ophthalmology, orthopedics, otorhinolaryngology, pediatric surgery, plastic surgery, proctology, thoracic, and urology. General surgery sessions will include emergency room care and utilization of surgical beds; surgical infections; the surgical/medical legal crisis; venous thrombo-embolism; esophageal replacement; hiatus hernia; duodenal ulcer; carcinoembryonic antigen for detecting carcinoma of the colon; wounds of the liver; surgical treatment of pancreatic trauma; and the role of the hospital in health care today and tomorrow. There is no registration fee for Fellows of the College, Non-Fellows pay \$15 and nurses are admitted free. For additional information and hotel registration write: Mr. T. E. McGinnis, Mgr. of Exhibits & Meeting Management, American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611.

Bellevue Stratford, Pennsylvania

March 13-16—American Academy of Facial Plastic and Reconstructive Surgery, Inc.

"Maxillofacial Trauma"

Directors are Sabino T. Baluyot, M.D., and Gabriel Marshak, M.D. A practical workshop in the treatment of maxillofacial features, including dissection of laboratory specimens. Fee \$400. For information and registration write: Miss Debby Adkins, Office of CONMED, Room 114, College of Medicine, University of Cincinnati, Cincinnati, Ohio 45219.

University of Cincinnati, Cincinnati, Ohio

March 15-16—Orange County Medical Society

"17th Annual Central Florida Medical Meeting"

Registration fee \$50 to OCMS members, \$100 to all others. No fee for interns & residents. For information write: Edward J. Edwards, Program Coordinator, Orange County Medical Society, 800 N. Mills Ave., Orlando, Fla. 32803.

Contemporary Hotel, Walt Disney World, Orlando, Fla.

March 16-17—Rockford Memorial Hospital

"Symposium—The Practical Approach to Female Reproductive Physiology"

This session will emphasize the basic science, as well as clinical concepts in reproductive endocrinology and infertility. Faculty will be made up of four members of the Baylor College of Medicine. For information write: Dr. Donald Burmeister, 2300 N. Rockton Ave., Rockford, Ill. 61103.

Rockford Memorial Hospital, Rockford, Ill.

(Continued on page 237)

ekg of the month

(Continued from page 215)

Answers:

- A. 2,3 The axis is left at -75° . The pattern of rsR in V_1 is caused by a right ventricular conduction delay as a result of either right ventricular hypertrophy or a form of right bundle branch block.
- B. 2,3 The findings of a systolic ejection click, systolic ejection murmur at the apex, fixed splitting of S_2 and a short tricuspid flow rumble are typical of atrial septal defect. Ostium primum defects usually have left axis deviation, whereas ostium secundum defects almost always have a rightward axis. Ostium primum defects commonly have associated a cleft of the mitral valve resulting in mitral regurgitation.

the viewbox

(Continued from page 211)

Diagnosis: *Mucoid carcinoma of the stomach* (Fig. 2).

An upper GI series reveals a constricting lesion in the pars media of the stomach with the surrounding calcifications again noted. On Figure 1 scout film, the diagnosis can be suggested noting the calcifications in the region of a constricted outline of the pars media region of the stomach. Figure 3 represents the surgical specimen with the gross punctate calcifications again noted. Calcification within gastro-intestinal tumors are rather rare and most of these represent mucoid adenocarcinomas and may be seen in either the stomach or the colon. Calcific metastasis may also be seen in the liver.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO AREA OFFICE: T. J. Pandak, J. C. Kunches, and L. R. Gannon, Representatives
T. J. Haehn, Consultant
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

What goes on

(Continued from page 235)

March 16-17—American Medical Association "25th National Conference on Rural Health"

Conference Goals: 1. To explore roles of health team members; 2. To examine responsibilities of public and private sector for rural health care delivery systems; 3. To review some possible solutions for rural health care delivery systems; 4. To assess the use of all resources in planning for and implementing health care delivery systems. For further information and registration, write: Council on Rural Health, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610, Attn: Bond L. Bible, Ph.D.

St. Francis Hotel, San Francisco, Calif.

March 16-18—Southern Society of Anesthesiologists

"Annual Meeting"

For information write: American Society of Anesthesiologists, 515 Bussee Highway, Park Ridge, Ill. 60068. New Orleans, La.

March 22—American Medical Association "The Quality of Life"

This Congress will concentrate on maternal health and child health from conception through adolescence—within a social, environmental and educational frame of references. Major emphasis will be on developing new programs that will contribute to the richness and depths of life . . . programs . . . sensitive to the physical, psychological, emotional and social needs of people . . . programs reflecting a trend towards more multidisciplinary cooperation. For information write: The Quality of Life, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

Palmer House Hotel, Chicago

March 25-26—Alfred Adler Institute

"Contributions of Adlerian Psychology"

For information write: Alfred Adler Institute, 110 S. Dearborn St., Chicago, Ill. 60603.

Obituaries

Grant V. Athanas, Chicago, died Jan. 3, at the age of 71. He was a Grant Hospital staff member for 47 years.

***Edward Berkwitz**, Chicago, died Jan. 6, at the age of 45. He was medical director of ambulatory services at Grant Hospital and was also on the faculty of the Northwestern University Medical School.

***Garland Brown**, Chicago, died Dec. 29, at the age of 72.

William Curtis, Chicago, died Dec. 24, at the age of 76. He was a supervising physician for the Chicago Board of Health.

Arian DeHaan, Belleville, died June 25, at the age of 83.

***Frederick J. James**, Paris, died July 6, at the age of 83.

Eleanor M. Humphreys, Chicago, died Dec. 28, at the age of 79. She was president of the Chicago Pathology Society and was a professor emerita at the University of Chicago.

***Wilber E. Keesey**, Chicago, died in January. He was a surgeon on the staff of Illinois Masonic Hospital since 1928 and was past president of the medical staff.

***Gustav Lawson**, Chicago, died Nov. 19, at the age of 85. He practiced medicine in Chicago for more than 40 years.

****Arthur E. Lehner**, Chicago, died Dec. 30.

***Isadore H. Meyers**, Oak Park, died in Dec. He was a physician and surgeon for 25 years.

***Albert Mickow**, Northbrook, died Dec. 7, at the age of 73. He had been on the staff of Ravens-

wood Hospital for 35 years and had established the Sauganash Medical Building in Chicago 25 years ago.

***Alphonse Mozan**, Chicago, died Jan. 3, at the age of 62.

****William A. Plice**, Chicago, died Dec. 19, at the age of 101. He had served on the staff of Illinois Masonic Medical Center when it opened in 1921.

***John R. Powell, Sr.**, Champaign, died Dec. 8, at the age of 74. He had been a physician and surgeon in Champaign since 1929.

****Oliver B. Simon**, Batavia, died Dec. 3, at the age of 77. He had been a physician for 54 years and was health officer in Batavia for 36 years.

Clyde P. Stollar, Park Ridge, died Dec. 31, at the age of 76.

****Christopher B. Stuart**, Springfield, died Sept. 18, at the age of 79.

***Alexandro G. Viteri**, Coal City, died Aug. 18, at the age of 48.

Dr. Karl A. Meyer, surgeon, teacher, and director of Cook County Hospital for 53 years, died Jan. 6, at the age of 86.

Described as the "finest surgeon in the U.S. at the peak of his career," an "automaton" and a surgeon whose "fingers had eyes," by colleagues, Dr. Meyer's reputation as a skilled administrator was equally impressive.

Under Dr. Meyer's direction, Cook County Hospital became one of the world's most sought after institutions for internships and residencies.

*ISMS Member

**50 Year Club Member

The word is out—"Flower Power!"

"FLOWER POWER" is the theme of the 44th Annual Convention of the Woman's Auxiliary to the Illinois State Medical Society. It will be held on March 8-11 at the Conrad Hilton Hotel in Chicago.

A special champagne reception honoring members-at-large will be held for all Auxiliary members in the Bel Air Room. You can register for the events of convention with your doctor-husband at central registration in the lower level.

On Wednesday, March 8, reports, elections and the budget will dominate the morning business meeting. Mrs. Prentiss Lee, president of the Woman's Auxiliary of the American Medical Society, will be the keynote speaker during the morning session.

Violets are the flower of convention and will backdrop the lovely fashion show "Flowers in Fashion" at the luncheon honoring Mrs. David Kweder, state president. A mini-workshop for county chairmen and state chairmen will close the afternoon.

"The Fairest Flowers of our Auxiliary Gardens" will be featured on Thursday, March 9, at our traditional County Day of reports. A special guest at the close of the morning session will be Mrs. Richard Ogilve, wife of our Governor. She will also visit informally during the Social Hour. The luncheon on Thursday will honor Mrs. August Martinucci, president-elect of the Auxiliary. Lewis College Drama Department will present Potpourri '72, a revue. County reports will be resumed in the afternoon.

More business and election of A.M.A. delegates will take place on Friday, March 11. Mrs. Martinucci and our new state officers will be installed for the coming year. A farewell brunch will be held at the Haymarket in the Conrad Hilton Hotel at the close of the session.

General Chairman of the convention is Mrs. Thomas Glatter and Mrs. Alfred Pagano is Vice Chairman.





report

a service of the american association of medical assistants, illinois society

Educational workshop scheduled for March 8

The Illinois Society, American Association of Medical Assistants, will hold an all-day educational workshop Wednesday, March 8, at the Conrad Hilton Hotel during the ISMS annual meeting.

The morning session will feature three speakers: Dr. Bennett R. Sherman, Glencoe, associate director, Evaluation Center for Learning Problems, Evanston Hospital; Dr. Jack Zackler, Chicago, assistant commissioner, Chicago Board of

Health; and Dr. Roland B. Mack, Riverside, chairman, Illinois Poison Control Department.

Afternoon speakers will be: Dr. Frank J. Jirka, Jr., ISMS president-elect; Miss Ruth Gallinot, Chicago, Continuing Education Division, Central YMCA Chicago; and Dr. Jerome H. Lippert, Chicago, Medical Consultant, Parkview Home for the Aged.

All medical assistants and physicians are invited.

Atlanta site of past 15th Annual Meeting

More than 600 medical assistants met in November in Atlanta, Georgia at the 15th Annual Meeting of the American Association of Medical Assistants. They came from as far away as Hawaii to compare notes, acquire knowledge and improve their skills.

Educational seminars were led by physicians from each specialty group. There was special emphasis on the radical treatment of kidney failure and a team from the Atlanta Regional Nephrology Center discussed "The Right To Die; To Walk Not Alone." Medical assistants were shown how they can help the patient and his relatives cope with terminal illness.

Other topics covered were national health care insurance, public relations and membership growth by such people as LeRoy William Natress, Jr., Chicago president of Natresources, Inc.; Leo Brown, assistant to the executive vice-president of the A.M.A.; and David G. Welton, M.D., Charlotte, N.C., member of A.A.M.A. Advisory Board.

Mrs. Helen Stephens, Ogden, Utah was installed as 1971-72 A.A.M.A. President by Mrs. Elvera Fischer, Chicago, a past-president of A.A.M.A.

American Association of Medical Assistants is a national organization of over 14,000 medical assistants including technicians, secretaries, office managers and other personnel. We work under the direct supervision of a licensed physician serving as the direct link between him and his patients. The main objective of this association is to provide education, to continue to increase the professionalism of medical assistants and to serve the doctor and his patients.

If you would like more information on how your medical assistant can become a member of this organization, please contact Mrs. Norma Domanic, 150 Ash Street, New Lenox, Ill. 60451 or Mrs. Vivian Kraft, R.R. #2, Normal, Ill. 61761.



your advertisers

Our Advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.

REGISTERED



MEDIA DATA FORM

CLASSIFIED ADVERTISING.....	239-240
INSURANCE	
Medical Protective	236
Parker, Aleshire, & Co.	220, 228
PHARMACEUTICALS	
Ayerst Laboratories Div., American Home Products, Inc.	
Premarin	126-127
Bristol Laboratories	
Versapen K	100
Burroughs Wellcome & Co.	
Empirin w/Codeine	2nd Cover
Eli Lilly and Company	
V-Cillin K, Pediatric	128
Flint Laboratories Div., Travenol Laboratories, Inc.	
Synthroid	104-105
Mead Johnson Laboratories	
Vasodilan	114-115
Merrell-National Laboratories	
Tepanil/Quinamm	209-210
Pfizer Laboratories, Pfizer Inc.	
Pfizerpen VK	124-125
A. H. Robins Co.	
Donmagel/Robitussin	108-109
Roche Laboratories	
Librium	112-113
Valium	Back Cover
Sandoz Pharmaceuticals	
Hydergine	118-119
Smith Kline & French Laboratories	
Ornade	123
Stuart Pharmaceutical Div., Division of I.C.I. America Inc.	
Mylanta	99
Kinesed	102-103
The Upjohn Company	
Orinase	110-111
Trobicin	120-121
Westwood Pharmaceuticals, Inc.	
Alpha Keri	221
SERVICES & CONTINUING EDUCATION	
Blue Cross/Blue Shield	97
Cook County Graduate School of Medicine	240
International Travel Advisors, Inc.	117
Jensen Distributors	
Jensen Interceptor II	240
Nationwide Pension Planning, Inc.	122

BLUE SHIELD REPORT



FOR *Illinois Physicians*

RECIPROCITY SYSTEM'S COVERAGE BENEFITS DESCRIBED

The National Association of Blue Shield Plans' new national Reciprocity System, which was developed to facilitate the handling of claims for services provided to out-of-state subscribers, provides coverage for a wide range of services. Payment is made on a 100% Usual and Customary basis which means that an Illinois physician will receive 100% of his usual fee when it is "within the range of usual fees charged by physicians of similar training and experience."

The physician is guaranteed payment from Illinois Medical Service for any of the services listed below which he provides to an out-of-state Reciprocity-eligible subscriber. This subscriber is easily identified by a special identification card which carries a double-pointed red arrow with a series of three numbers preceded by the letter "N" in the upper left corner. (See our February, 1972 article for further details.)

Benefits under the Reciprocity System include:

SURGERY—Wherever performed including operative or cutting procedures, treatment of fractures or dislocations, and endoscopic procedures.

ASSISTANT SURGEON—Coverage when such service is certified as necessary and house staff, interns or residents are not available for such service.

ANESTHESIA—Wherever performed for covered services when administered by a physician other than the operating physician or his assistant.

RADIATION THERAPY—Wherever performed for services provided by a physician for X-ray, radium, or radioactive isotopes, including rental of materials unless supplied by a hospital or other institution.

DIAGNOSTIC X-RAY—Including interpretation and report, while the subscriber is a registered bed patient in a hospital when such examination is consistent with the diagnosis, or in the outpatient department of a hospital or in a physician's office when the examination is performed as a direct result of an injury.

LABORATORY AND PATHOLOGY—Examination in a hospital when consistent with the diagnosis or in the outpatient department or physician's office when performed as a direct result of an injury.

IN-HOSPITAL MEDICAL CARE—Any medical treatment by the attending physician for a condition not related to surgical or maternity care for the first 30° days of each hospital admission. Concurrent medical care benefits will be provided for surgical care patients if the service is rendered by another physician for medical complications.

PULMONARY TUBERCULOSIS, MENTAL

DISORDERS, DRUG ADDICTION, AND CHRONIC ALCOHOLISM—Coverage for the first 30° days of each hospital admission.

OUTPATIENT EMERGENCY CARE—Necessary services performed by a physician wherever performed for an accidental injury or for the first visit at the onset of a medical emergency.

CONSULTATIONS—Services of another physician when requested by the attending physician for advice in diagnosis or treatment of a condition which requires such special skill or knowledge while the member is a bed patient in a hospital.

The Reciprocity System *does not cover* maternity services, dental or nursing services, appliances or supplies, operations for cosmetic purposes, care obtained in U.S. Government hospitals, care obtained without cost, Workmen's Compensation cases, services primarily for diagnostic purposes, or claims for Medicare beneficiaries.

If you have any questions regarding the Reciprocity System, contact your Professional Relations Representative or the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601—(312) 661-4594.

**Number of days varies according to individual group contract.*

Spring Series of Workshops Scheduled

The Spring series of dinner workshops for medical assistants in central and southern Illinois has been scheduled by the Blue Shield Plan of Illinois Medical Service.

The workshops are intended to aid medical assistants in carrying out their responsibilities more effectively for their physician-employers and to inform them of changes in Blue Shield benefits and of ways to file Physician's Service Report forms to prevent delays in payment.

All medical assistants will be invited to attend one of the workshops and should return promptly the reservation form which will be included in the invitation.

The following eighteen dinner workshops are scheduled:

Wednesday, April 5	Ramada Inn	Mount Vernon
Thursday, April 6	Ramada Inn	Marion
Wednesday, April 12	Hyatt House	Belleville
Thursday, April 13	Holiday Inn	Edwardsville
Wednesday, April 19	Fountain Lodge	Olney
Thursday, April 20	Ramada Inn	Effingham
Wednesday, April 26	Decatur Club	Decatur
Thursday, April 27	U.S. Grant	
	Motor Lodge	Mattoon
Wednesday, May 3	Ramada Inn	Champaign
Wednesday, May 17	Holiday Inn	Bloomington
Thursday, May 18	Ramada Inn	Peoria
Wednesday, May 24	Holiday Inn	Quincy
Thursday, May 25	Sheraton Inn	Springfield
Wednesday, May 31	Sheraton Inn	Rock Island
Thursday, June 1	Sheraton Inn	Galesburg
Wednesday, June 7	Ramada Inn	Ottawa
Thursday, June 8	Ramada Inn	Kankakee
Wednesday, June 14	Henrici's	Rockford

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Requesting Payment on Behalf of an Incapable Person

Medicare regulations require that all SSA 1490, Request for Medicare Payment, forms be signed by the patient (with the exception of claims for Public Aid recipients or deceased patients). When a patient is unable to execute the request himself because of a mental or physical condition, the claim may be executed on his behalf by a legal guardian, representative payee (a person designated by the Social Security Administration or other government agency to receive the incapable person's monthly benefits), relative, friend, representative of an institution providing him care, or representative of a governmental agency providing him assistance.

A physician or his employee can sign on behalf of the patient only *under extraordinary circumstances*, fully documented to show that the patient is unable to sign for himself and that there is no other person authorized to sign for him.

To sign for an incapable person, a representative of an "institution providing him care" should be an employee of an old age or retirement home or a hospital, either general or psychiatric. An old age or retirement home is defined to be an institution which contractually provides room, board, and medical or other services to persons who commonly enter and remain there for life even though in good health. An extended care facility or a nursing home would not be considered "an institution providing him care" unless the patient has no friend, relative, or other person who exercises responsibility for his affairs.

When a claim is filed on behalf of an incapable person, the name of the patient should be shown on the signature line of the SSA 1490 followed by "by" and the name and address of the requestor. The requestor, other than the guardian or representative payee, should also attach a statement to the SSA 1490 explaining his relationship to the patient and the reason the patient cannot sign.

Labs Outside Your Office Must Be Identified

Whenever a physician submits a claim for an office visit which includes charges for laboratory tests made outside the office, the laboratory *must be identified* on the SSA 1490, Request for Medicare Payment form.

If the laboratory is not a Social Security Administration approved Independent Clinical Laboratory or if an approved laboratory performs a test for which it is not certified, the claim for laboratory services *must be denied*. Should a test or other

laboratory service be referred from one independent laboratory to another independent laboratory, the laboratory actually performing the test must be certified in that specialty. The name of the laboratory actually performing the test should be made known to the physician and should be indicated on the SSA 1490.

Denial of coverage for a laboratory test does not affect the coverage of the office visit which usually includes the physician's charge for evaluating and interpreting the laboratory report. These will be covered in the usual manner regardless of whether the laboratory claim is paid or denied.

Information Needed on Medicare 1490 Claim Forms

In order to improve the processing time of an SSA 1490, Request for Medicare Payment form, Illinois Medical Service, as a Part B Medicare carrier, conducted a study to determine the items of information most often omitted from a claim, causing delays in payment. The study indicated six major areas where needed information was omitted.

DIAGNOSIS: The diagnosis is essential in order for the Part B carrier to relate the services provided to the treatment of the illness or injury. A diagnosis should be indicated for any service provided, whether it be surgery, an office visit, or an order for an item of durable medical equipment.

DATE(S) OF SERVICE: Each date that service was provided should be indicated.

ITEMIZATION OF ALL CHARGES: The date of each service, description of each service, and charge for each service included on the SSA 1490 should be indicated. For example, a bill for several office visits plus in-hospital medical care should list the date and charge for each office visit plus the dates and charge for the in-hospital care.

ITEMIZATION OF SPECIFIC CHARGES: The charge for a specific service included in an overall charge should be indicated. For example, a charge for an office visit during which a complete blood count was taken and an injection given should include the charge for the complete blood count and the charge for and type of injection as well as the charge for the office visit.

HEALTH INSURANCE CLAIM NUMBER: Every claim submitted must include the patient's complete Health Insurance Claim Number, including the letter suffix, as it appears on the patient's Health Insurance Card.

PHYSICIAN IDENTIFICATION: This should include the first name, last name, middle initial, address and telephone number and, when the physician accepts assignment, the *signature* of the physician and the patient.

The absence of this information results in the delay of approximately 3,000 claims per week. Missing information must be obtained by telephone call or letter, both of which are time consuming and costly to all concerned. By making sure that all the necessary information is included on the SSA 1490, you can help us to provide better service to you and your patient.



illinois medical journal

volume 141, number 3

March, 1972

staff

editor	Theodore R. Van Dellen, M.D.
managing editor	Richard A. Ott
assistant editor	Michaelyn Sloan
advertising manager	John A. Kinney
executive administrator	Roger N. White
Abstracts of Board of Trustees actions	251

clinical articles

Ulcerative colitis—Selected clinical, diagnostic and therapeutic aspects <i>James L. Franklin, M.D., and Joseph B. Kirsner, M.D.</i>	277
Choosing the safest ski binding <i>Hugh A. Johnson, M.D.</i>	238
Maternal death study case report No. 1 <i>Robert E. Hartman, M.D.</i>	291
Comparative study of—Myfadol and meperidine as postoperative analgesics <i>Morton Shulman, M.D., Max S. Sadove, M.D., and Charles Bomberger, C.R.N.A.</i>	293

special article

Take one allergist . . . an idea . . . and a publisher The result? A READ-ORING BOOK! <i>Michaelyn Sloan, ISMS staff writer</i>	299
---	-----

surgical grand rounds

Ectopic pregnancy	284
-------------------------	-----

features

the presidents page	258
editorials	261
clinics for handicapped children	270
the view box	283
ekg of the month	287
new pharmaceutical specialties	301
practice management	302
obituaries	304
the peer reviewer	305
illinois society, medical assistants	312
pulse of the doctor's wife	316
socio-economic news	317
what goes on	326

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.



Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601. Copyright, 1972, The Illinois State Medical Society.

Subscription \$5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$7.50 per year for all foreign countries included in the Universal Postal Union. Canada \$5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

REGISTERED
AIA
MEDIA DATA FORM

The new RocomTM Medical Management System...

helps solve these five vexing office problems

- 1. taking health histories**
- 2. maintaining meaningful patient records**
- 3. handling incoming telephone calls**
- 4. keeping appointments on schedule**
- 5. providing useful supplemental patient instructions**

Each component in the new ROCOM Medical Management System* deals with a specific office problem to help you provide better patient care and improve the use of your office time.

In designing these products, hundreds of doctors, nurses and receptionists were consulted about their particular office problems. More than two years of development under actual office conditions proved that the ROCOM systems actually do help solve difficulties without upsetting existing office routines.

In private or group practice, most physicians will find one or more of these products useful. The components can be employed alone, in various combinations, or preferably as the complete ROCOM Medical Management System, depending on your own office situation. To obtain additional information, please send this coupon to ROCOM-- the health information and education division of Hoffmann - La Roche Inc.

1. ROCOM Health History System provides maximum screening information about the patient with a minimum expenditure of your time. Prior to your examination, the patient answers 129 carefully chosen questions arranged by body system. Only positive answers transfer through to the summary sheet. You get an immediate picture of the patient's current complaints with the knowledge that important screening questions are covered. SOMETHING NEW...ROCOM HEALTH HISTORY SYSTEM (Spanish) -- Questions are in Spanish, answers in English. The form does the "translating."

2. ROCOM Medical Record System a simple but comprehensive method for keeping a complete record on every one of your patients. Permits you to review a patient's medical history in seconds and retrieve information quickly. Can be used with the "problem-oriented" method of keeping patient records. Color coding virtually eliminates the likelihood of misplaced files. A disease cross-index card keeps track of patients by disease entity. Family Jacket Holder keeps all medical records of an individual family in one location. Well-kept records can be one of the greatest deterrents to malpractice suits. The ROCOM Medical Record System helps protect your good name.

3. ROCOM Telephone System a complete system; one that can be understood quickly by your newest office aide; one that permits your staff to answer specific patient questions with confidence; one that will make your practice more productive by assuring that you are interrupted only when you think it necessary. Self-adhesive backing assures that all incoming calls can become part of the patient's permanent record.

4. ROCOM Appointment System worked out by you in your own practice with the help and guidance of ROCOM. Time segments are individualized to your own requirements. Can be coordinated with your colleague's or nurse's schedule. Helps keep a steady flow of traffic through the waiting room. An unlimited variety of schedules available.

5. ROCOM Patient Health Guide a series of 25 education aids that provide basic knowledge to supplement your counselling and instructions. Follows a question and answer format. Tested for accuracy and effectiveness in private medical practices. This literature is "patient-oriented" not "product-oriented." A convenient holder for storage of the Guides is also available.

Abstracts of Board actions Board of Trustees meetings

January 15-16, 1972

Chicago, Illinois

Deficit Budget to be Presented to House

The Illinois State Medical Society, which managed to balance its budget during five inflationary years without raising its dues or curtailing membership services, completed 1971 \$29,717 in the red, based on unaudited figures. Anticipating another deficit budget in 1972, the Board of Trustees recommended that \$15,725 be taken from permanent reserves to balance the 1972 budget. It also plans to recommend House of Delegates approval for a dues increase for 1973. The last dues increase was voted by the 1965 House and took effect in 1966.

Increased Accidental Death Coverage Approved

The Board also approved a Finance Committee recommendation that accidental death policies carried for ISMS officers, trustees and senior staff members be increased from \$50,000 to \$100,000 and that another class of coverage for council and committee members, AMA delegates and alternates, members of the Woman's Auxiliary and other ISMS staff personnel be increased from \$25,000 to \$50,000.

Object to Education Budget Cuts

The Board will ask Governor Ogilvie not to accept the Illinois Board of Higher Education's recommendations for cutting the budgets of institutions training health manpower. The Board said that such action would be a serious threat to the supply of trained professionals and that the Health Education Commission's recommendations represent the actual needs of the state.

Appoint Directors for Statewide Continuing Education Council

The following were appointed ISMS representatives to the Independent Statewide Council on Continuing Medical Education:

Drs. Dean Bordeaux, J. Ernest Breed, Herschel Browns, Edward W. Cannady, Robert T. Fox, Jack Gibbs, Mather Pfeiffenberger and George Shropshear. Together with a representative from each of the seven medical schools in Illinois and the College of Osteopathy, they will form the Board of Directors of the Statewide Council. Dr. Breed was appointed interim chairman.

Residents' Dues

The Board will request the AMA to waive its 1972 residents' dues for Illinois because ISMS and the Chicago Medical Society had already printed and mailed their 1972 dues bills before the AMA established dues for residents.

Definition of Death

On recommendation of an Ad Hoc Committee set up to define death, the Board adopted the following criteria:

1. Absence of spontaneous respiration and absence of cardiac function, or
2. Absence of spontaneous respiration and absence of brain function which is judged to be irreparable and irretrievable.

The Governmental Affairs Council was instructed to prepare legislation stating that either of these definitions shall be utilized for all purposes in Illinois, including the trials of civil and criminal cases, any laws to the contrary notwithstanding.

Abstracts of Board actions

Student Records in Liability Cases

The Council on Education and Manpower was asked to study the problem of patient chart notations by medical students with respect to their being used in malpractice suits. The Council was requested to advise the Board how student comments on the patient record could be considered an educational exercise rather than a physician's medical record.

Task Force on Physician Shortage

The Board authorized the Task Force on Physician Shortage to explore the possibility of obtaining a grant from HEW to inaugurate a system of health care delivery by picture-phone. This technique was suggested as a means of bringing certain physician services to areas of the state where doctors are not readily available.

Council on Economics & Peer Review

On recommendation of the Council on Economics and Peer Review, the Board approved merging the Advisory Committee to the Division of Vocational Rehabilitation with the Committee on Rehabilitation Services.

Additions to Peer Review Guidelines

The Board approved the Council's suggestions for additions to the Peer Review Guidelines and these will be distributed to county medical societies and district peer review committees. The Council's request to purchase AMA Peer Review Manuals for local peer review committees was denied because the Board believes that the responsibility of purchasing these manuals should be left to the county medical society.

Endorse Institute of Gerontology

In accordance with recommendations from the 1971 White House Conference on Aging, the Council on Social and Medical Services requested that a resolution endorsing establishment of a National Institute of Gerontology be introduced by the ISMS delegation at the Annual Meeting of the American Medical Association. The Board concurred.

Task Force on Comprehensive Health Planning

The Board of Trustees approved a Task Force request to cosponsor all future ISMS regional conferences on Comprehensive Health Planning and Trauma Centers with local CHP "B" agencies. It is believed that the co-sponsorship would increase physician attendance by making the conference more relevant to area physicians.

Smallpox Vaccinations

The Council on Environmental and Community Health was instructed to bring to the March Board meeting a definite recommendation on the position ISMS should take on the proposal to delete compulsory smallpox vaccinations from the Illinois School Code. In view of the national controversy over mandatory smallpox vaccinations the Board said ISMS members should have guidelines on contraindications for vaccinations and there should be continued study of the advantages and disadvantages of eliminating mandatory vaccinations.

Rubella Immunization

The Board approved a recommendation from the Council on Environmental and Community Health that the following priorities for rubella immunization be accepted:

1. School age (5-12);
2. Pubertal females;
3. Infants (1-5);
- and 4. Women of child-bearing age only after HI test and proper pregnancy preventive measures.

(Continued on page 308)

			Animal Gland		
CYTOMEL (Sodium liothyronine) Synthetic T ₃	EUTHROID** (Liotrix) Synthetic T ₃ -T ₄	THYROLAR*** (Liotrix) Synthetic T ₃ -T ₄	Desiccated (Thyroid, USP) Cow, sheep or hog thyroid	PROLOID (thyroglobulin) Frozen hog thyroid	SYNTHROID (Sodium levothyroxine) Synthetic T ₄
Unscored 5 mcg.	N.A.	N.A.	unscored ¼ gr.	¼ gr.	0.025 mg.
N.A.	½	½	unscored ½ gr.	½ gr.	0.05 mg.
25 mcg.	1	1	unscored 1 gr.	1 gr.	0.1 mg.
N.A.	N.A.	N.A.	N.A.	1½ gr.	0.15 mg.
50 mcg.	2	2	unscored 2 gr.	2 gr.	0.2 mg.
N.A.	3	3	unscored 3 gr.	3 gr.	0.3 mg.
N.A.	N.A.	N.A.	unscored 5 gr.	5 gr.	0.5 mg.
N.A.	N.A.	N.A.	N.A.	N.A.	Injectable 500 mcg.

N.A. = Not Available Commercially

*Equivalents shown are chemical, and do not take into consideration individual patient variables. Clinical effect is approximate and should be monitored when converting a patient to SYNTHROID. This is particularly important in patients previously on desiccated thyroid. In these patients, lower doses of SYNTHROID may produce the same metabolic effect.

**Euthroid (#1 tablet) contains 60 mcg. of T₄ and 15 mcg. of T₃.

***Thyrolar (#1 tablet) contains 50 mcg. of T₄ and 12.5 mcg. of T₃.

Synthroid®

(sodium levothyroxine)

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for Injection is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Morton Grove, Illinois 60053

THE FACTS ARE CLEAR AND HERE IS OUR OFFER.

Synthetic thyroid drugs are an improvement over animal gland products. Patients, even athyrotic ones, can be completely maintained on SYNTHROID (T₄) alone. Thyroid function tests are easy to interpret since they are *predictably* elevated when the patient adheres to SYNTHROID. Of all synthetic thyroid drugs, SYNTHROID is the most economical to the patient.

OFFER:

Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

Name _____

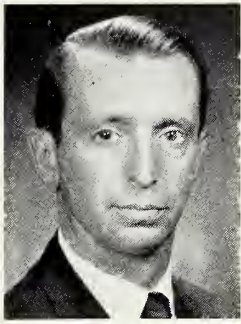
Address _____

City _____

State _____

Zip _____





the presidents page

L. T. Fruin, M.D.—In memoriam

L. T. Fruin, M.D., the 121st President of the Illinois State Medical Society, died on Feb. 5, 1972, eight months and five days after being installed as the new leader of our society.

Dr. Fruin was a candid man, who spoke out forcefully on such issues as government involvement in medicine and the need for evolution, not revolution, in our health care delivery system.

His 35 years of experience in the private practice of medicine—a profession too silent in the past—led him to deliver an inaugural address in which he spoke out with such force against the critics of medicine that the news media labelled him, “the angry doctor.”

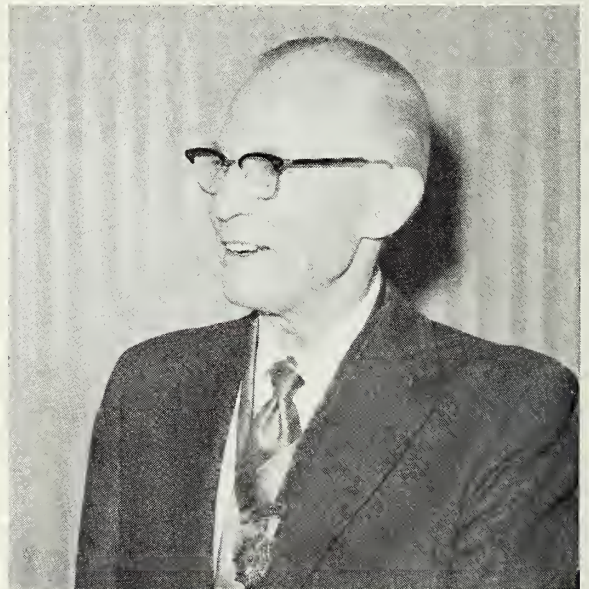
During his regrettably brief tenure in office, L. T. Fruin did indeed “speak up” to both consumers and physicians alike. He called them as he saw them and the all too silent image of the physician became alive.

As Miguel de Cervantes, the Spanish novelist, wrote:

“The road is always better than the Inn.”

Those who settle at the Inn call it quits and miss the whole point of life. Men like Dr. Fruin prefer to travel the road, no matter how rocky.

All that mattered to Dr. Fruin were the lessons learned along the way. And he not only learned his lessons well . . . but he spoke out



loud and clear about what he had learned.

L. T. Fruin, M.D., gave to this society a new and forceful posture . . . a posture that will live on with his memory.

Frank J. Jirka Jr. M.D.



editorials

"Turf" and Illinois' new medical schools

The establishment of new centers of medical education at Rockford, Peoria, Urbana, Springfield and Carbondale is one of the most exciting developments in medical education in the country. As candidates, consultants and visitors pass through Springfield and my office, it is quite obvious that the "Illinois Plan" is gaining broad national visibility and may well set a prototype for many of the new medical schools planned around the country the next 10 to 15 years.

By placing the first year in the existing resources of our major universities and the clinical years in existing regional centers, the savings in capital costs alone are probably close to \$100 million per school. Further advantages are the speed of development and strategic placement. While Chicago and St. Louis have long been sophisticated centers of medical education, one cannot avoid the observation that the impact and nourishment of the university medical center decreases with distance as a simple fact of logistics.

It is obvious, looking at the five cities mentioned above, that the Health Education Commission was thinking geographically when the new centers were designated and that there are "turf" implications. The recent division of the state into service regions further clarifies these geographic responsibilities.

From the medical school's point of view, speaking for myself though I suspect Drs. Cotsonas and Evans would concur, the messages from the citizens, professionals and institutions in our respective regions leave no doubt that they have expectations of what "their medical schools" will mean to them. In the process of our relating to citizens in Central and Southern Illinois, a very clear message is coming across. *If by the end of this decade the people in our area are not get-*

ting more and better health care, the new medical school will have been unsuccessful, regardless of how many graduates it has. An Illinois graduate practicing in California is not the goal.

Thus, while we are all pushing to get under way and expand our manpower programs as quickly as resources allow, this program alone is not sufficient as a goal. Particularly for the downstate centers, we must put a high priority on effective programs of continuing education, information systems, and consultation that transparently enhance the professional rewards of practicing in Illinois, hopefully so effectively that they not only hold and nourish the doctors we have, but also begin attracting doctors from other states and, of course, hold our own graduates. The goal to be achieved is that every Illinois physician will have effective access for himself and his practice to the resources of his medical school.

The increasing furor over health care delivery systems also has serious and urgent implications for the new medical school. The almost inevitable advent during this decade of some form of 100% financial access to health care will place unparalleled demands on limited manpower and the creativity of the system to come up with practical solutions. Thus, the new schools must be prepared to contribute their resources, along with other educational institutions and hospitals in the regions to educate more and new allied health professionals, to increase the effectiveness of the doctors we now have, and to bring the resources and expertise of the Illinois State University System to assist the health professionals and institutions in finding workable mechanisms for delivering effective health care. Such competencies as management, economics

(Continued on page 266)

When irritable colon feels like this



Trobicin®

sterile spectinomycin dihydrochloride
pentahydrate, Upjohn
single-dose intramuscular treatment

High cure rate: * 96% of 571 males, 95% of 294 females
(dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

Assurance of a single-dose, physician-controlled treatment schedule

No allergic reactions occurred in patients with an alleged history of penicillin sensitivity
when treated with Trobicin, although penicillin antibody studies were not performed

Effective against most strains of *Neisseria gonorrhoeae* in vitro (M.I.C. 7.5-20 mcg/ml)

Single two-gram injection produces peak serum concentrations averaging about
100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included.

JA72 184B-6

bin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no concentration changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 6 hours after reconstitution with diluent.

Dosage—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Dosage—single 4 gram dose (10 ml) intramuscularly.

How supplied: Vials, 2 and 4 grams—with ampoule of Bacterio-

satic Water for Injection with Benzyl Alcohol 0.9% w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

For additional product information, see your Upjohn representative or consult the package insert.

MED-B-1-S (LWB)

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Illinois' new medical schools

(Continued from page 261)

and medical sociology that exist in our universities should be available to the doctors of this state as they enter the complex years ahead. In no way do I suggest that the medical schools or universities design or run the health care delivery system. Their proprietorship would not only be inappropriate but almost certainly ineffective. We do have much to contribute in technical skills, however, and since the medical schools as well as the profession will be judged by the result, I feel we are obliged to be contributing partners to the process.

Our goal is a common one: we want a system that is effective, accessible, economical, and always of high quality in human as well as in scientific terms.

Our medical school has received magnificent support from the State Medical Society and particularly from the societies in Sangamon and Jackson counties where we now have over 140 clinical faculty members, and our ability to work and plan together for educational goals is established. Now as the doctors and institutions work increasingly to develop new structures of health care, it is important that the medical schools participate. At a minimum, we must know the system in which our graduates will practice. At the best, we should assist in maximizing the impact of the important resources to which we have access.

An array of individuals and agencies, private and governmental, are presenting their versions of the solution to the health care problem. I suspect that some broad guidelines and ground rules will develop inevitably at the national level over the next few years, but from what I have seen

in terms of actual progress, I think the most creative activity is happening at the local area level where needs and opportunities are in much better focus. I am concerned that leadership in this critical philosophic area is being pre-empted away from organized medicine, and I applaud the increasing activities in various county societies and at the state level which show signs of getting it back. It is in that light that I propose exploring an opportunity.

The pattern of planning at the regional level in Illinois seems set though not yet effective. I think that it is inevitable that the medical schools will be called upon by agencies to assist in planning in their regions, but planning agencies and medical schools cannot take care of large numbers of people—only the doctors of this state can do that. What I would particularly like to see is a new or amended organizational structure within the state society that would give effective voice to the organized physicians *in each planning region*. To plan without the doctors simply will not work. To plan with some of the doctors or to plan at cross purposes, at the very least, will cause confusion and delay and, at worst, the catastrophe of a rigid national solution.

The regional organization of physicians with consumer support, armed with the resources of their medical schools offers, in my opinion, the best hope of meaningful progress and the return of the profession to its proper role of leadership.

Richard H. Moy, M.D.
Dean, Southern Illinois University,
School of Medicine

"Regularizing" physician's assistants

The most popular legislative approach to "regularizing" physician's assistants has been that of framing an exception to the state's medical practice act, authorizing supervised delegation of tasks by the physician. Such statutes have existed in several states (Arizona, Colorado, Kansas and Oklahoma) prior to the formal establishment of physician's assistant programs. The basic objective of such an approach is to allow the physician to receive assistance without fear of incurring liability by delegating to unlicensed personnel. The physician's potential liability for an assistant's **incompetent** performance is assumed to provide adequate and effective assurance of the patient's welfare. (E. Harvey Estes.: "Physician's Assistants: Ethical and Legal Issues," *The Internist*, Oct., 1971, pgs. 1 and 4-5.)

caring better for her basic needs,
less confused in her thinking; no great
accomplishment for most people, but a
significant advance for the arteriosclerotic
patient with cerebrovascular insufficiency

Hydergine[®]

SUBLINGUAL TABLETS containing 0.167 mg. dihydroergocornine
methanesulfonate, 0.167 mg. dihydroergocristine methanesulfonate,
and 0.167 mg. dihydroergokryptine methanesulfonate

helps patients with cerebrovascular
insufficiency due to arteriosclerosis
do little things better

The usual dosage is four to six sublingual tablets daily. The patient's improvement
with Hydergine is usually demonstrated in four to six weeks. Some nasal
stuffiness due to adrenergic blockade, transient nausea or gastric disturbances
have been reported with high dosages.

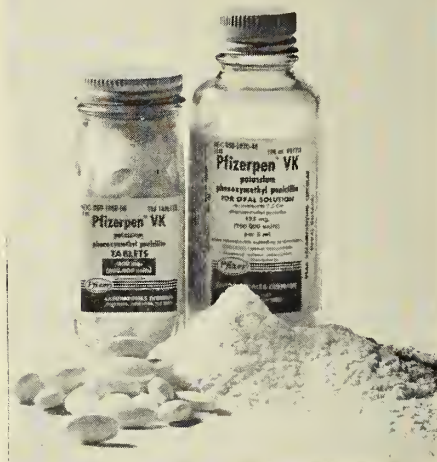
April clinics listed for handicapped

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will hold 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

April—

- 4 Quincy—St. Mary's Hospital
- 5 Hinsdale—Hinsdale Sanitarium
- 5 Rock Island Cerebral Palsy—Foundation for Crippled Children
- 5 Metropolis—Massac Memorial Hospital
- 6 Sterling—Sterling Community Hospital
- 6 Lake County Cardiac—Victory Memorial Hospital
- 6 Flora—Clay County Hospital
- 6 Cairo—Public Health Department
- 11 Peoria—St. Francis Hospital
- 11 E. St. Louis—Christian Welfare Hospital
- 12 Champaign-Urbana—McKinley Hospital
- 13 Springfield—St. John's Hospital
- 14 Chicago Heights Cardiac—St. James Hospital
- 18 E. St. Louis—Christian Welfare Hospital
- 18 Rock Island Area General—Moline Public Hospital
- 19 Chicago Heights General—St. James Hospital
- 19 Centralia—St. Mary's Hospital
- 19 Mt. Vernon—Park Avenue Baptist Church
- 20 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 20 Bloomington—Mennonite Hospital
- 20 Rockford—Rockford Memorial Hospital
- 24 Peoria Cardiac—St. Francis Children's Hospital
- 25 Peoria—St. Francis Children's Hospital
- 26 Aurora—St. Joseph Mercy Hospital
- 28 Chicago Heights Cardiac—St. James Hospital
- 28 Evanston—St. Francis Hospital

PFIZERPEN DOSAGE FORMS



**Orange-flavored
Pfizerpen VK for Oral Solution**
(potassium phenoxymethyl penicillin)
125 mg. (200,000 units)/5 cc.:
bottles of 100 cc. and 150 cc.
250 mg. (400,000 units)/5 cc.:
bottles of 100 cc. and 150 cc.

Pfizerpen VK Tablets
(potassium phenoxymethyl penicillin)
250 mg. (400,000 units): bottles of 100.
500 mg. (800,000 units): bottles of 100.



**Butterscotch-caramel-flavored
Pfizerpen G Powder for Syrup**
(potassium penicillin G)
400,000 units/5 cc.:
bottles of 100 cc. and 200 cc.

Pfizerpen G Tablets
(potassium penicillin G)
200,000 units: bottles of 100 and 500.
250,000 units: bottles of 100.
400,000 units: bottles of 100 and 1000,
and unit-dose pack of 100 (10 x 10's).
800,000 units: bottles of 100.



I M J

Illinois Medical Journal

Vol. 141, No. 3, March, 1972

BY JAMES L. FRANKLIN, M.D., AND JOSEPH B. KIRSNER, M.D., PH.D./CHICAGO

Ulcerative colitis Selected clinical, diagnostic and therapeutic aspects

IT IS NOW over 100 years since Sir Samuel Wilks first described ulcerative colitis in 1859. It is interesting to look at the description of this disease as it appeared in 1893 in *THE PRINCIPLES AND PRACTICE OF MEDICINE* by Sir William Osler. Here in three brief paragraphs we encounter some of the features (pseudopolyp formation, dilatation or contraction of the colon and perforation) that we would recognize as characteristic of ulcerative colitis. Our expanded concept of this disease is reflected in the fact that modern textbooks usually devote an entire chapter to this topic. While these provide an expert opinion and overview of the subject, the limitation of space prevents indepth discussion of individual areas. The purpose of this review is to bring into focus the sources of our current understanding of selected clinical, diagnostic and therapeutic aspects of ulcerative colitis.

Epidemiology

Reports of nonspecific ulcerative colitis continue to appear from racial groups or geographic locales previously considered to be resistant, such as: Africans,^{1,2} Bedouin Arabs,³ Costa Rica,⁴ India,⁵ and Japan.⁶ While these reports support a global distribution of inflammatory bowel disease, studies which satisfactorily estimate incidence, prevalence, and mortality have been confined to western countries. Table I summarizes

the findings of several such surveys. Within a given geographical area, the racial distribution of ulcerative colitis has been found to vary. Wigley and MacLaurin⁹ reported a prevalence among European New Zealanders of 41 per 100,000 while the non European New Zealanders—the Maoris—experienced a prevalence of only 2.5 per 100,000. Mendeloff et.al.¹⁰ found a significantly lower incidence of colitis in the non-white population of Baltimore than that in the white (0.45 per 100,000 versus 3.5 per 100,000).

Ulcerative colitis

Table I
Incidence and Prevalence of Ulcerative Colitis

Country	Period Covered by Study	Incidence*	Prevalence*
Norway		7	1.2
New Zealand		9	24
Copenhagen	1961-1967	8	41.3
Oxford	1951-1960	13	7.3
Baltimore	1960-1963	12	6.5
Costa Rica	1958-1968	4	79.9
		—	42
			1.6

A summary of several major epidemiologic studies listing incidence and prevalence of ulcerative colitis.

*Cases per 100,000

Examining the frequency of Jewish patients discharged from Veterans Administration Hospitals with a diagnosis of colitis, Acheson¹ documented a four-fold increase above the expected number. Mendeloff^{10,12} also has demonstrated a greater prevalence of both ulcerative colitis and regional enteritis among the Jewish population of Baltimore. The preponderance of patients of the Jewish religion could not be demonstrated in the Oxford study¹² or by the experience of physicians in Leeds.¹⁴ That this increased frequency of inflammatory bowel disease in Jews is unique to the U.S., is supported by the experience of Birnbaum¹⁵ in Israel. A low incidence of ulcerative colitis was noted there, although the frequency in Occidental Jews was greater than that among Oriental Jews.

Ulcerative colitis seems to occur more frequently among the higher socioeconomic groups¹⁶ and in groups with a higher level of educational attainment.¹⁷ An assessment of illness experience and life stress events failed to show differences from a control population.¹⁸

The underlying genetic factor in inflammatory bowel disease is reflected in the occurrence of more than one member in the same family in 10-15% of patients^{19,20} and this incidence has been shown to be statistically beyond the range of mere chance.²¹ A similar etiologic relationship between ulcerative colitis and Crohn's disease is suggested by the appearance of various combinations of these syndromes within the same family. The importance of genetic factors perhaps is further strengthened by the association of urticaria and allergic rhinitis in relatives of patients with colitis.²² A recent study²³ has emphasized the importance of immunologic phenomena shared by patients with colitis and their first degree relatives.

Age of onset with a peak incidence up to the

ages of 20-30, has been similar in different geographical locales. The incidence then falls off until the age of 55-60 when there is a second sharp rise in incidence and then a final decline into old age. This biomodal distribution has suggested two disease entities,¹³ which will be considered in a later section on differential diagnosis.

An on-going computerized analysis of the epidemiologic data on the 1400 patients being seen at the University of Chicago²⁴ has largely confirmed these observations.

Local complications of ulcerative colitis

Toxic Megacolon

Acute dilatation of the colon or toxic megacolon is one of the most life-threatening events complicating the course of ulcerative colitis. Recent case reports substantiate the occurrence of toxic dilatation of the colon in granulomatous colitis,²⁴⁻²⁶ an event hitherto considered unlikely. The incidence of toxic megacolon varies with the institution. McInerney²⁸ reported an incidence of 3% in 1,230 patients at the Mayo Clinic, Edwards and Truelove²⁹ in 1.6% of their 624 patients, while Jalan,³⁰ in Edinburgh, recorded an incidence of 13% among 399 patients with colitis.

Toxic dilatation of the colon may occur in a patient with ulcerative colitis during the first attack of the disease or after having had colitis for many years.³¹ The patient presents with pronounced abdominal distention, generalized tenderness, markedly reduced bowel sounds, fever, mental confusion, and a decrease in the number of stools per day. It is agreed,^{14,27} that frequently these classical signs may be absent and the essential factor in early recognition of this problem includes an awareness of its existence and the routine practice of daily abdominal radiologic examinations in all patients with acute colitis. Neschis,³² in a study of 50 consecutive cases, found that dilatation exceeding 6 cm. in the transverse colon as is measured on an abdominal

film, and the presence of a sub-serosal radiolucent line parallel to the colon to be reliable criteria for the diagnosis of toxic dilatation of the colon. Classical radiological signs of perforation often are absent, probably due to rapid sealing of the perforation.

The pathology of this complication is that of a dilated fragile bowel with a consistency comparable to that of wet tissue paper; on microscopy there is transmural inflammation with edema of the thinned muscularis propria, and hydropic degeneration of Meissner's plexus.

Pre-disposing or precipitating factors include:³¹ injudicious use of narcotics or anticholinergics; cathartics used in preparation for a poorly timed roentgen study of the colon; and hypokalemia. A temporal relationship has been observed between the initiation or increase in opiate administration and the occurrence of toxic dilatation of the colon. Garrett³³ has shown that in patients with ulcerative colitis, opium is a potent stimulant of colonic motility while anticholinergics do not seem to have an effect on the colonic motility.

The mortality associated with this complication has ranged from 21 to 50%. The higher figure apparently has included patients treated during the pre-steroid era.³⁰ Perforation is associated with toxic dilatation in approximately 33% of cases^{28,31} and contributes to the high mortality. Perforation, however, will be recognized by clinical observation in somewhat less than 50% of patients.³⁰

While Norland and Kirsner³¹ were able to successfully treat 70% of their patients medically, 23 of these 32 patients so managed ultimately had a colectomy (72%). Jalan³⁰ emphasized that most of the mortality in medically treated patients occurs in the first 10 days of hospitalization. They favor early operation, strengthening this recommendation with the argument that most of these patients will ultimately come to colectomy.

In treating the individual patient, meticulous attention must be paid to the administration of parenteral fluids and electrolytes with an attempt to induce positive nitrogen balance. Intestinal drainage, preferably with a long tube such as a Cantor or Miller-Abbot tube, should be instituted. Blood cultures are positive in a third of such

patients and parenteral broad spectrum antibiotic coverage should be instituted after blood cultures have been obtained. Massive hemorrhage may complicate 10% of cases and the transfusion requirements must be met with an attempt to maintain the hematocrit and hemoglobin levels in a physiologic range. Hypoalbuminemia is almost universal and should be corrected. Hypokalemia is present in probably no more than 30% of these cases, but the use of steroids can be expected to intensify potassium loss and its level must be carefully monitored. Hydrocortisone in parenteral dosages of 300 mg per day are routinely employed. The concomitant usage of 40 units of intravenous adrenocorticotrophin³² is favored by physicians familiar with this complication; but the value of this adjunctive medication is unclear.

Collaboration with a surgical team should be initiated at the onset and failure of the patient to respond significantly in 24-48 hours are indications for total colectomy and ileostomy. A one stage proctocolectomy is favored as the procedure choice.^{30,34} Van Prohaska³⁵ felt that the presence of perforation was the outstanding factor contributing to mortality in the surgical patient. This experience is shared by other groups.^{30,32} Arguments favoring early colectomy are strengthened by the difficulty in recognizing perforation in a patient with toxic megacolon.

Carcinoma

The increased frequency of carcinoma of the colon in patients with ulcerative colitis is well recognized and is remarkably similar in various centers. (Edwards and Truelove, 1964,²⁹ 3.5%; MacDougall, 1964,³⁶ 3.3%; Goldgraber and Kirsner, 1964,³⁷ 2.8%; Walsh and Hedberg, 1965,³⁹ 3.3%). It is estimated, based on the incidence of colon cancer for hospital admissions, that the risk of carcinoma of the colon in the ulcerative colitis patient is 5-10 fold that of the general population. In patients with total involvement of the colon the incidence of colonic cancer is greater than in patients with left-sided involvement or ulcerative proctitis. The yearly and cumulative incidence rises sharply when the disease has been present for greater than 10 years and reaches a cumulative incidence of greater than 40% after 25 years.³⁹ The onset of ulcerative colitis in child-

JAMES L. FRANKLIN, M.D., is with the University of Chicago, Pritzker School of Medicine, Department of Medicine, Section of Gastroenterology.

JOSEPH B. KIRSNER, M.D., Ph.D., is with the University of Chicago, Pritzker School of Medicine, Department of Medicine, Section of Gastroenterology.

Ulcerative colitis

hood may carry with it a greater risk of carcinoma⁴⁰ however; this may also reflect a longer survival or greater frequency of total colonic involvement.

Carcinoma in the colitic colon tends to be multicentric and highly invasive due to its tendency to arise as a sessile polyp as opposed to a lesion on a stalk; indeed, a linitus plastica-like pattern of growth has been described.⁴¹ Because carcinoma of the colon and ulcerative colitis have a common constellation of symptoms and due to the deformity of the colitic colon by pseudopolyp formation and stricture, the early diagnosis of cancer in these patients is difficult. The steep increment in the yearly incidence of carcinoma of the colon occurring after 10 years of ulcerative colitis and the difficulties in diagnosis have led some authors^{36,39a} to advocate prophylactic colectomy for patients with disease of more than 10 years duration and with total colonic involvement. This less than satisfactory solution has led to a search for a better means of early diagnosis.

Methods under consideration include: colonic exfoliative cytology, premalignant histology on rectal biopsy, carcinoma-embryonic antigen, fiberoptic colonoscopy and cytogenetic studies. The presence of undifferentiated malignant cells on smears obtained by colonic washing is regarded as reliable evidence for the presence of colonic cancer⁴². Difficulties with this method have resulted from the need for careful preparation of the patient⁴³ and the presence of so-called "active and bland" cells found in ulcerative colitis, cells which are difficult even for an experienced cytologist to interpret. Morson and Pang⁴⁴ have described mucosal changes which they have correlated with the presence of malignancy. These changes are: loss of normal parallelism of the epithelial glands; a villous growth pattern with lateral budding; and misplacement of proliferating epithelial tubules through the muscularis mucosa. The cytologic changes include: fewer goblet cells; irregularity in size and shape of cells; enlarged hyperchromatic and stratified cell nuclei; prominent nucleoli and coarse chromatin pattern with increased nuclear to cytoplasmic ratio. In a study of mucosal lactic dehydrogenase isoenzyme patterns in patients with this premalignant change,⁴⁵ these same authors found an abnormal pattern consisting of an increase in the proportion of slow moving isoenzymes similar to that seen in malignant colonic tissue and in malignant tissue from other sites in the body.

In 1965 Gold and Freedman⁴⁶ described the presence of an antigen (carcino-embryonic antigen, CEA) in extracts of colonic carcinoma tissue not present in similarly prepared extracts of normal colon tissue. The antigen has been detected by radio-immunoassay⁴⁷ in the serum of a large group of patients with a variety of intestinal neoplasms. In a recent report⁴⁸ antigen levels were detectable in 10 of 31 patients with ulcerative colitis who had no evidence of a neoplasm. In light of these findings, the utility of CEA antigen as a test for the recognition of carcinoma in ulcerative colitis remains in question.

Considering the more proximal distribution of carcinoma of the colon in patients with ulcerative colitis, the fiberoptic colonoscope⁴⁹ may prove useful in the evaluation of suspicious lesions seen on radiologic studies. Currently only a few centers in the U.S. have this instrument and published experience is forthcoming. Studies⁵⁰ in the cytology laboratory at the University of Chicago currently underway, are exploring the possibility of carcinoma detection in ulcerative colitis through chromosomal counting and tissue karyotyping.

The future usefulness of these methods remains to be determined. Today they are still at an investigational level and the recognition of carcinoma of the colon in the patient with ulcerative colitis remains a vexing problem for the clinician.

Systemic manifestations

Arthritis

The occurrence of arthritis in association with ulcerative colitis has been recognized since 1929.⁵¹ The arthritic complications of inflammatory bowel disease include: colitic arthritis; sacroiliitis; ankylosing spondylitis and clubbing. The somewhat variable frequency of these syndromes is summarized in Table II.

The arthropathy of colitis is characterized by recurrent acute synovitis—usually asymmetrical, monoarticular, and commences in the knees and ankles. This syndrome is clinically, radiologically and serologically distinct from rheumatoid arthritis.⁵¹ The sex distribution is approximately equal and the age of onset between 25 and 45. Wright and Watkinson^{51a} found the arthritis to be strongly correlated with the severity, extent, and duration of the colitis. Jalan⁵² more recently has not been able to make this correlation. At-

Table II
Articular Symptoms in Ulcerative Colitis

	Fernandez-Herlihy 1959 (555 pts.)		Edwards & Truelove 1964 (264 pts.)		Wright & Watkinson 1965 (269 pts.)		Jalan 1970 (399 pts.)	
Syndrome	No.	%	No.	%	No.	%	No.	%
Colitic Arthritis	18	(3.2)	35	(5.6)	31	(11.5)	27	(6.8)
Sacro-iliitis	28	(5.0)	11	(1.8)	18	(5.5)*	17	(4.2)
Spondylitis					15	(5.5)	20	(5.0)
Clubbing								
Arthralgias	23	(4.2)						
Total and (%) with Arthritis	69	(12.4)	46	(7.4)	46	(7.4)	64	(16)

*42 of 234 patients analyzed prospectively

tacks of arthritis often coincide with exacerbations of intestinal symptoms, but residual clinical disability, joint deformity or radiologic changes have been uncommon.

Ankylosing spondylitis occurs more often in colitic patients than would be expected from its frequency in the general population.⁵³ In a prospective study of 234 colitics, Wright and Watkinson⁵⁴ found radiologic sacro-iliitis in 18% in contrast in 4% in a group controls. Thirteen of the patients clinically had ankylosing spondylitis. The predominance of males was less marked than is usually noted. Sacro-iliitis did not bear a relationship to the severity, extent or duration of the intestinal disease^{54,55} which was in contra-distinction to colitic arthritis. McEwen et. al.⁵⁶ observed that spondylitic symptoms were more likely to precede the onset of intestinal disease than colitic arthritis.

Systemic complications, in particular uveitis and erythema nodosum, are frequently associated with both colitic arthritis and ankylosing spondylitis. Local complications, perianal disease and pseudopolyps, also have been more frequently associated with colitic arthritis than with sacro-iliitis or ankylosing spondylitis.

Young⁵⁶ attempted to evaluate the influence of the vagus nerve on the pathogenesis of clubbing by taking advantage of its partial innervation of the colon. Comparing the frequency of clubbing in 79 patients with total colonic involvement to that of 79 patients with distal colonic involvement he noted seven cases of clubbing in the former group while none could be found in the latter group. Jalan,⁵² however, comments on the development of finger clubbing during an attack of colitis in a patient who had previously undergone truncal vagotomy for duodenal ulceration. Whatever the role of the vagus nerve, clubbing has been frequently associated with severe disease, the presence of carcinoma and toxic dilatation.

The influence of surgery on the course of the articular manifestations of ulcerative colitis is not entirely certain. Fernandez-Herlihy⁵³ found that 10 of 11 patients with colitic arthritis who underwent colectomy continued to experience arthritis and similarly, 12 of 15 patients with spondylitis exhibited progression of their arthritic disease. Only one patient of the 15 with arthralgias experienced continued symptoms after surgery. McEwen et.al.⁵⁶ noted failure of arthritis to improve in four of 10 patients undergoing total colectomy. This experience differs from that of Wright and Watkinson⁵¹ who believe that colitic arthritis can improve with colectomy while spondylitis will not be influenced by surgery. Arthritis probably is not sufficient justification for colectomy although it is likely to be associated with severe intestinal disease in which there are already strong indications for surgical intervention.

Ulcerative Colitis in Childhood (Growth Retardation)

The onset of ulcerative colitis in childhood is associated with a poor prognosis.⁴⁰ In the first two decades of life, the frequency and severity of attacks as well as the percentage of medical failures and deaths are greater than in the subsequent two decades of life.⁵⁸ The explanation for this increase in morbidity and mortality lies in the greater frequency of universal colonic involvement, approaching 70%⁵⁹ and in striking contrast to that seen in adult patients. Equally disheartening are the studies of Korelitz^{60,61} comparing the course of childhood colitis in the pre-steroid era with that of the steroid era and failing to demonstrate a decrease in the percentage of patients requiring surgery or the overall mortality. In discussing the surgical aspects of colitis in childhood, most authors are in agreement that these patients can adjust successfully to an ileostomy. A defunctioning ileostomy or colostomy

Ulcerative Colitis

diverting the fecal stream does not stop the progression of the disease. Subtotal colectomy with a rectal mucous fistula still leaves the patient with an organ vulnerable to carcinoma; the hope of re-anastomosis is seldom realized.⁶²⁻⁶⁴

Growth retardation has been recognized as a complication of regional enteritis and ulcerative colitis in childhood. Along with arthritis and pyoderma gangrenosum, it is the most frequent extra-intestinal complication. Korelitz and Gribetz commented that this complication was noted more frequently in the steroid era. A systematic study of this problem at our institution⁶⁵ revealed that 22 of 130 children with inflammatory bowel disease were below the third percentile in height. Endocrine evaluation demonstrated abnormally low 24 hours urinary gonadotropin with a depressed growth hormone response to insulin-induced hypoglycemia. Growth retardation was attributed to hypopituitarism and was not invariably associated with corticosteroid therapy. Malnutrition and possible loss of trace metals such as zinc,⁶⁶ deficiency of which has been associated with growth failure, deserve consideration as contributory factors. Resection of diseased bowel has tended to be followed by a spurt of linear growth and percentile growth increment.

Liver Disease

Liver disease arising as a complication of ulcerative colitis is now well recognized. The various forms that this liver injury may take to some extent are known. It is clear that the prevalence of liver disease will reflect the manner in which the patients to be studied are selected (e.g. autopsy material, surgical biopsies taken at the time of colectomy, or percutaneous liver biopsy). Carefully designed prospective studies assessing clinical and biochemical parameters of liver and biliary tract disease and accompanied by biopsy material will afford a better understanding of the relationship of the problem to inflammatory bowel disease. A study designed along these lines currently is in progress in the section of gastroenterology at the University of Chicago.

Liver pathology in ulcerative colitis has occurred with a frequency ranging from 3-5% for cirrhosis to 94% occurrence of histologic abnormalities found in biopsies taken at the time of colectomy.⁶⁹ The hepatic lesions associated with ulcerative colitis include: fatty infiltration, pericholangitis, cirrhosis, chronic active hepatitis and biliary cirrhosis. Primary sclerosing cholangitis

(a fibrosing disease of the intra and extra hepatic biliary ducts),⁷⁰ cholangiocarcinoma and carcinoma of the gall bladder⁷¹⁻⁷² occur with increased frequency in ulcerative colitis.

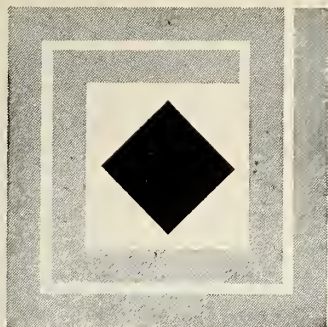
Fatty infiltration, the most common lesion found in postmortem studies,^{67,73} has been observed less frequently in antemortem studies.^{74,75} It occurs in 45% of patients at the time of colectomy being of a moderate to severe degree in only 14%. The extent of the fatty infiltration correlates with the severity of the clinical disease at the time the liver biopsy is obtained.

In antemortem studies, pericholangitis has been found to be the dominant pathologic lesion. Mistilis⁷⁶ classifies the lesion into acute, subacute and chronic based on the nature of portal inflammation and the extent of circumductal fibrosis. Others,^{69,77-78} argue that the term pericholangitis is unacceptable because the process involves the portal vein and lymphatics. These authors prefer the term "triaditis" to emphasize involvement of all the elements in the portal field. The pathogenesis of this lesion is uncertain. Portal bacteremia⁷⁹ was detected by cultures of portal blood and liver tissue in 24 of 100 patients at the time of proctocolectomy for ulcerative colitis. Portal bacteremia was not found to correlate with the presence of liver disease and appropriate controls were lacking. Portal bacteremia was found in those cases where the intestinal disease was of the greatest severity.

Pericholangitis may present clinically with recurrent fever, abdominal pain, and an enlarged liver. Cholestasis with a variable degree of jaundice, pruritus and elevation of serum cholesterol and alkaline phosphatase will be present. Jaundice has persisted for as long as two years before subsiding spontaneously. The benefits of long term tetracycline therapy have been disappointing⁸⁰ and steroids do not clearly alter the course of the disease. The observations of Eade et.al.⁶⁹ suggest that there is a lack of progression of the lesion and possibly a regression following colectomy in cases where cirrhosis has not been already established. It is not clear that colectomy has a place in the management of the liver disease of ulcerative colitis.

Australian workers who initially promoted the idea that pericholangitis progressed to a primary biliary cirrhosis now believe that this is not the case and have proposed clinical and histologic

(Continued on page 321)



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



Fig. 1

This 43-year-old female entered the hospital with complaints of increasing constipation of several years duration. Considerable difficulty occurred in an attempt to sigmoidoscope the patient and the patient was referred to Radiology for a barium enema. (Figures 1, 2 and 3)

What's your diagnosis?

- (1) Granulomatous colitis
- (2) Ulcerative colitis
- (3) Lymphogranuloma Venereum
- (4) Linitis plastica of the colon

(Answer on page 320)

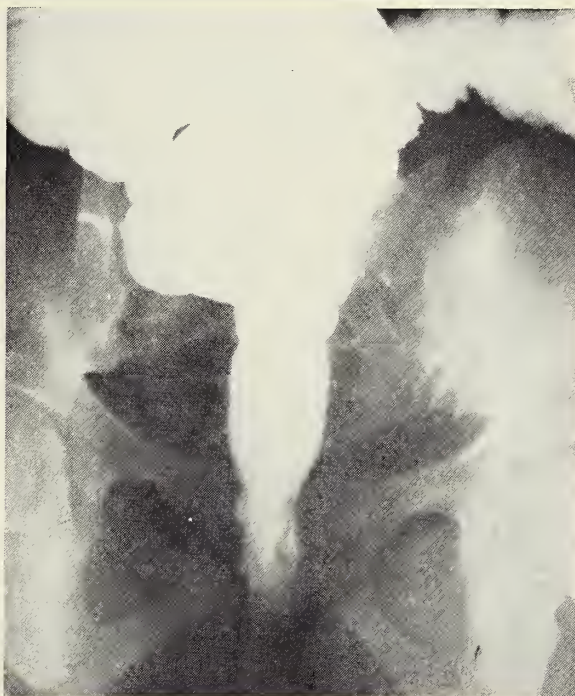


Fig. 2

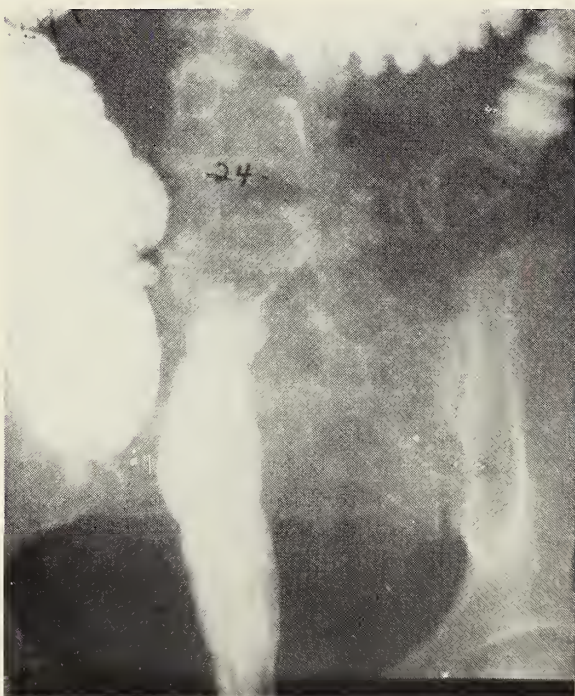


Fig. 3



surgical grand rounds

EDITED BY JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Ofield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 19, 1971.

Ectopic pregnancy

Case Report

Dr. Richard Peyton: The patient, a 24-year-old gravida 0 para 0 black woman, was admitted to the emergency room at Passavant Memorial Hospital at 10 a.m. with a history of nausea and right lower quadrant pain. The previous night she had experienced mild low back pain and episodes of nausea. On her way to work as a nurse's aid, she again experienced nausea and faintness while riding on the bus. On arrival, she continued to feel nausea and faintness, and had an onset of right lower quadrant pain, which she described as constant. She was seen first in the emergency room by the intern, and right lower quadrant rebound tenderness was noted. When pelvic examination was performed, pain was caused by manipulation of the cervix.

Menstrual history revealed abnormal uterine bleeding which was treated by a dilatation and curettage in August, 1970. Since then, her periods have been regular, every 30 days, flow lasting four to five days. Previous period was three weeks prior to this time; it was stated to be normal in onset and duration. The present episode was not associated with vaginal bleeding.

Physical examination: Blood pressure on admission to the emergency room was 90/60, pulse 82, temperature 99.6°F. Hemoglobin was 13.5 gm., white count 12,500 with 79% polymorphonuclear leukocytes. Examination of the abdomen revealed slight obesity, rebound tenderness in the right lower quadrant; bowel sounds were present and active. Pelvic examination revealed marital introitus, vagina normal, cervix was

tender with motion. There was tenderness in the right adnexal region. Uterus, tubes and ovaries were not palpated because of pelvic pain. She was taken to the X-ray Department for films of the abdomen, and while standing for a film of the abdomen, she fainted. She was returned to the emergency room where her orthostatic hypotension was confirmed. Culdocentesis yielded dark non-clotting blood. Laparotomy was performed and a left tubal pregnancy was found. Left salpingectomy was performed.

Dr. Melvin Gerbie: This lady presents what seems to be the yearly occurrence of a Passavant employee who develops hypotension while having an X-ray taken and turns out to have a tubal pregnancy. This woman has been a patient of mine for the last three and a half years, and I have seen her on numerous occasions. She had a dilatation and curettage performed last fall for irregular bleeding and her periods were just starting to get straightened out when the present episode occurred. Initially, the patient stated her periods were normal, but on further questioning she stated that her last period started only two weeks after what she considered a normal menses. She really didn't have any abdominal pain prior to coming to the hospital, but she felt lightheaded a couple of times on the bus coming to work. She had had to get off the bus and felt better, which is the reverse of what happened in the hospital. The patient was seen and examined by numerous people in the emergency room. The numerous exams are a problem in our patients, since there is no one that I know of that could have three or four rectal and vaginal exams and not have a tender cervix on rectal examination by the time the next person examined her. I think the third or fourth prostate exam is probably also a bit on the tender side. Cervical tenderness is something I would like to talk about briefly. Frequently I am asked to see patients whom I have been told have cervical tenderness, but I cannot corroborate the finding. When examining the vagina or the rectum and reaching up for the cervix and asking the patient, "Does that hurt?" the answer 99% of the time is going to be "Yes." Of course it hurts, and whether it hurts from the finger just stretching the skin or is anal sphincter pain or vaginal tightness is hard to tell. She says "It hurts," we say, "It must be the cervix," because that is what we are touching. Most of the time you can touch the cervix and move it around and look at the patient, and she will tell you by her expression whether it hurts or not.

I thought she had inflammatory disease or appendicitis at the time of initial exam. Her abdominal tenderness was much too high for what I considered a pelvic process; however, on pelvic exam, there was definitely more lower tenderness as well, and this disparity was the reason I asked for surgical consultation. Dr. Poticha saw her and actually met her in the X-ray Department. Her findings were mainly limited to the right side and I thought she had appendicitis. Dr. Peyton thought she had a right adnexal process. I also thought maybe it was an inflammatory process because she also had a little left-sided tenderness, but tubal pregnancy could not be ruled out. Because of this question, there being no palpable mass, with normal blood counts, and with her documented hypotension, we did a culdocentesis putting in a needle through the vagina into the cul-de-sac and obtaining about 10ccs of non-clotting blood. We think this is an important test in these patients. In patients whose vital signs are normal, without a mass in the pelvis, this is a large help in making a diagnosis. Let me caution you not to show the patient the needle before doing the procedure. The needle for culdocentesis is actually a three and one-half inch spinal needle, but to a patient it looks like it is about a foot long, and the size of a javelin. I would suggest not showing it to the patient and getting it prepared out of the patient's view. The non-clotting blood was obtained and we took the patient very quickly thereafter to the operating room and found, as is often the case, a tubal pregnancy on the opposite side of her clinical findings. Actually this girl had a large corpus luteum in the right ovary, with the tubal pregnancy in the left tube. This is not uncommon. Apparently, there is transmigration, either extrauterine or through the uterus into the other tube. We removed the tube and did a cornual resection of the uterus, taking out about one centimeter of uterine wall, including that portion of tube that is the uterus. There is a question of whether or not the ovary should be removed. Some people have felt that by leaving in an ovary on the side of the removed tube, chances of a repeat tubal pregnancy on the other side are increased. We do not believe an ovary should be removed unless it is indicated, however, often it is indicated. In ruptured tubal pregnancy, frequently the blood supply to the ovary is in jeopardy, and the ovary must be sacrificed. This is a decision to make at the time of operation. The cornual resection removes a small portion of uterus, and

Ectopic pregnancy

is done to prevent implantation of an egg in the portion of the tube in the uterine wall.

There is a new problem in the last few years that is occurring in patients with intrauterine devices. I thought you might be interested in this aspect, because a patient with an intrauterine device may be seen with abdominal pain. The past reputation of the IUD has made most people think of an inflammatory process, but tubal pregnancies can and do occur with intrauterine devices. So your index of suspicion must be kept high. Culdocentesis, as I mentioned before, is a valuable procedure. In a recent issue of the *British Medical Journal*, 100 patients in whom culdocentesis was done were reported. (*Brit. Med. J.* 1:200, 1970) There were three false negatives, and four false positives. The false positives had other sources of intraperitoneal bleeding which required operation; the false negatives were three unruptured ectopic pregnancies and one pregnancy that had ruptured into the broad ligament. It is not an "all or none" test, but it is a very useful test.

We don't treat these patients with antibiotics. They usually respond very quickly to immediate operation and their temperature comes down. In the past, the patients used to be held up in the operating room until blood could be replaced, but most of the time as soon as blood pressure was reestablished the tube would start to bleed again, and the patient would be farther and farther behind. Blood should be cross-matched and made available while the patient is being opened. In some situations when blood isn't available, people have used autotransfusion, just taking the blood out of the peritoneal cavity, and filtering it through a sponge, and putting it into a bottle with anticoagulant in it and replacing it immediately. We have not had to use this method, and I wonder if any of you have had experience with autotransfusion.

This is a disease that requires a high index of suspicion. We see many patients in our office, and in the clinic, and in the emergency room with abdominal pain, irregularity in periods, and a little bit of tenderness. Obviously everyone of them is not operated upon. We don't mind operating upon a girl for an ectopic and finding something else. I'm sure you don't mind having that happen with some of the acute surgical conditions. One other interesting problem is what we call our Friday afternoon syndrome; the girl who comes in with an apparent incom-

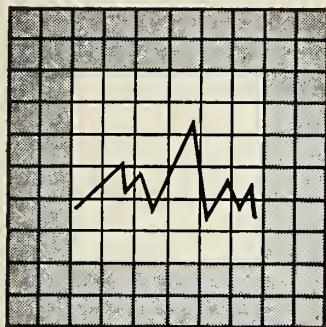
plete abortion on Friday and a D & C is done. The patient goes home on Saturday, but Monday or Sunday she calls you with increasing lower abdominal pain. She comes back to the hospital in shock and turns out to have an ectopic pregnancy. The tissue that she passed, or what was obtained by curette was decidual tissue and not placenta. So when tissue is passed and the patient is thought to have an incomplete abortion we still watch out for an ectopic pregnancy until we see the microscopic slides or a gross fetus. Contrary, there are many patients with an early uterine pregnancy who have an enlarging corpus luteum producing a tender ovary. We keep in close contact with these patients until we are satisfied that they don't have a tubal pregnancy, occasionally hospitalizing and even exploring surgically to find a normal pregnancy.

Dr. John Beal: Dr. Poticha, you saw the patient in the X-ray Department following the episode of fainting. Would you comment on the significance of this?

Dr. Stuart Poticha: The physical findings in acute appendicitis are the result of a localized peritoneal irritation in the right lower quadrant. Since many diseases may produce such a localized peritonitis, the correct diagnosis often depends upon an accurate history. In this case the history of faintness in addition to right lower quadrant pain gives the physician an important clue for establishing a correct diagnosis. Patients with acute appendicitis practically never exhibit signs of orthostatic hypotension. The symptoms of lower abdominal pain in association with faintness, dizziness or syncope occurring in a woman of childbearing age, should immediately alert the physician to the diagnosis of ruptured ectopic pregnancy.

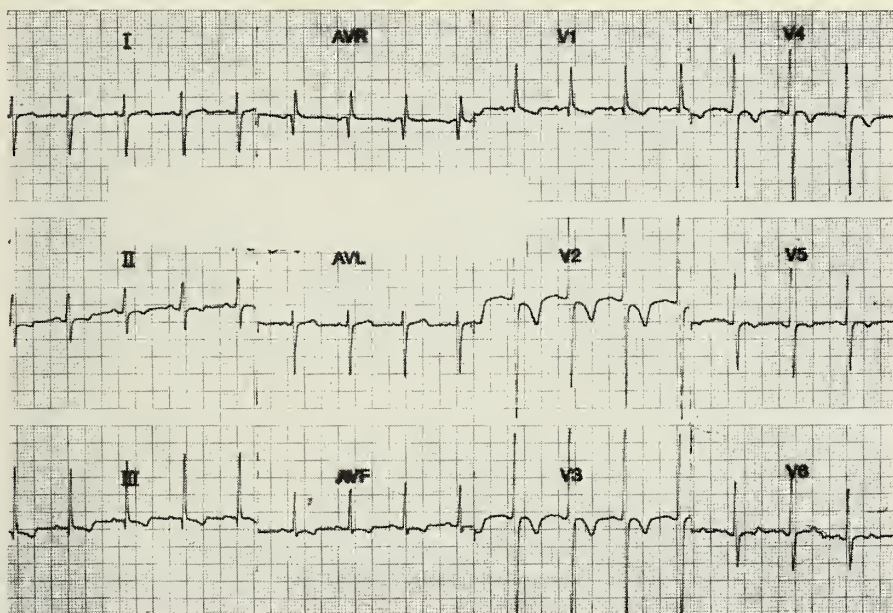
Once considered, specific steps can be taken which help to confirm this diagnosis. In this case the woman reported a normal menstrual period three weeks prior to the onset of this illness. However, further questioning revealed that the patient had a short irregular menstruation 12 days before her last normal menstrual period. This additional history further suggested a diagnosis of ruptured ectopic pregnancy. Orthostatic hypotension was searched for and clearly demonstrated. A culdocentesis was performed. The presence of non-clotting blood in the cul-de-sac confirmed the diagnosis of ruptured ectopic pregnancy.

(Continued on page 324)



ekg of the month

JOHN R. TOBIN, JR., M.D., M.S., RIMGAUDAS NEMICKAS, M.D.,
PATRICK SCANLON, M.D., JOHN F. MORAN, M.D. AND JAMES
V. TALANO, M.D./SECTION OF CARDIOLOGY,
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This 30-year-old female was perfectly well until six months ago when she first noticed dyspnea, chest discomfort and lightheadedness with exertion. She is now limited to very mild activity by these symptoms.

Examination reveals a blood pressure of 120/90; pulse is 96 and regular. There is neither cyanosis nor clubbing. A prominent jugular A wave is seen. There is a distinct right ventricular lift. A loud systolic ejection click is present along the left sternal border. S_2 is finely split, and the pulmonary component is distinctly increased in intensity. A faint S_4 is heard at the lower left sternal border. No murmurs are present.

Questions: (One or more of the choices may be correct.)

- A. The electrocardiogram reveals:
 1. Right bundle branch block.
 2. Left axis deviation.
 3. Right axis deviation.
 4. Right ventricular hypertrophy.
 5. Left bundle branch block.
- B. The following are suggested clinically:
 1. A form of Eisenmengers reaction is present (reversal of intracardiac shunting secondary to development of pulmonary hypertension).
 2. Primary pulmonary hypertension is likely.
 3. Mitral stenosis is present.
 4. Prognosis is quite good.
 5. There is no specific therapy for this patient.

(Answer on page 320)

Choosing the safest ski binding

The post-ski season is a good time for examining and evaluating your equipment before storing it away. The following article provides some medical insights into the use of good equipment—a most useful article to read before making any ski equipment purchases during the sales and mark-downs now in session.

“A FRACTURE FOR every ten years of skiing” is the aphorism, but I doubt it’s statistically sound. At least it doesn’t apply in my family—we’re five and have skied a total of 91 years. We’ve had but two fractures, one the result of improper bindings and the other the result of faulty judgment. Both could have been prevented. The faulty bindings were my old bear trap type toe pieces put onto my nine-year-old daughter’s skies (to save a few dollars!) I’d been told that children don’t have ski fractures. Her fracture was a spiral of the femur, what one would expect at that age. The other fracture was mine, a compression of T 11, & 12, a frozen clod of earth under a light powder snow on a too-advanced slope. Bindings, however, will not compensate for stupidity.

If a binding were to be made to release under all pressures that might cause a fracture one couldn’t keep the skies on the feet. Each type of binding is therefore a compromise. Each skier must make a decision as to how much risk he will accept.

To what authority can one turn? Perhaps the most un-biased would be *Consumer Reports*, published by The Consumers Union. They tested ten brands and listed the following as “acceptable:” Cubco Standard, Look Nevada, Marker Simplex toe unit with Marker Telmat heel (with another Marker heel unit, the combination is rated “Unacceptable”) and Dovre. Consumers Union, the testers, used various testing devices. Of the devices used to test, they rated the Lipe Skier’s Release Check (\$14.95) as the best testing device. Lipe (Gordon Lipe, University of Vermont) therefore should be the authority. He is the binding consultant for *Skiing* magazine. Lipe

favors the “Cubco” for beginners when safety is more important than performance. Other experts agree the Cubco to be best for children, their Junior Model being specifically designed for children up to 90 lbs.

Gordon Lipe says of the Salomon—the brand I would choose—“The price is relatively high (made in France)—high quality, durable construction, handsome in appearance, light in weight, easy to get in and out of.”

For my next authority I turned to America’s largest ski manufacturer, the Head Ski Co. The manager of Product Development, John Howre, says “For racers, experts and intermediates I favor Marker Simplex toe and Ratomat heel.”

Enough about choice of binding; you can see it’s like buying a sports car—which meets one’s needs, which expert one consults, and what one



Fig. 1. Marker bindings in use. Over half the racers at the winter Olympics used these bindings.



Fig. 2. The Salomon toe release binding is my personal choice.

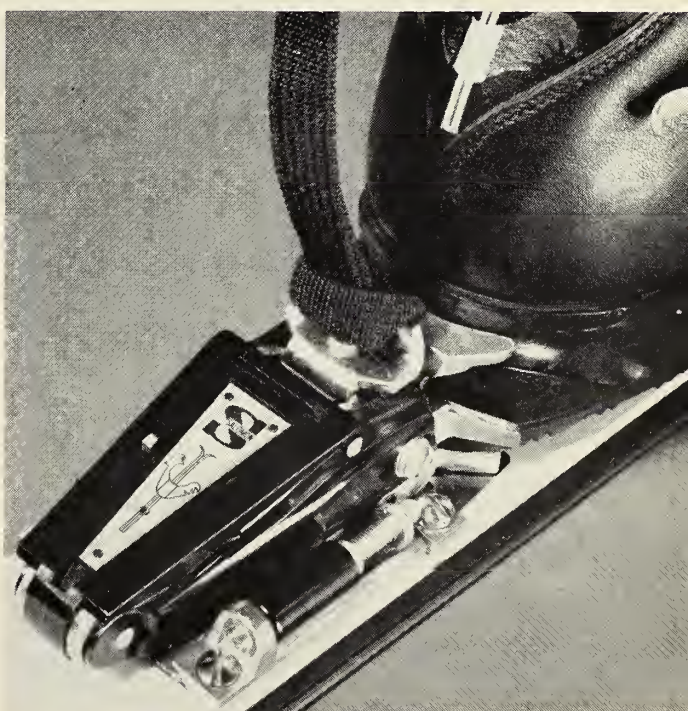


Fig. 3. The Salomon heel binding.

Safest Ski binding



Fig. 4. Cubco step-in ski binding.



Fig. 5. Safest bindings for children 90 lbs. and under.

wants emotionally. But no binding is any better than its adjustment.

Thus, bindings must be:

1. Carefully fitted to your boots, right and left, by an expert after purchase from a reputable dealer. Buy your equipment well before the last minute rush in order to insure proper mounting on your skies (proper position is very important for every binding).
2. Bindings must be in proper condition. Clean off last year's road salt *now* and oil all moving parts, and then adjust, adjust, adjust. Spray with silicone to reduce friction and ice formation. Failure to do these simple things is the cause of most fractures no matter what binding is chosen.

You shouldn't have to be warned about skiing under control, about using common sense regarding the effects of fatigue, etc. Remember, though, osteoporotic bones can be made more dense with exercise. Get in shape!

Conclusion

The safest ski binding is your personally selected binding adjusted by an expert, then regularly and rigidly oiled and checked for function, and used under control.

HUGH A. JOHNSON, M.D., is in the private practice of plastic and reconstructive surgery in the Rockford Memorial Medical Building at the Rockford Memorial Hospital. Dr. Johnson has been a Fulbright Lecturer in plastic surgery at the Christian Medical College in Vellore, India, and later in Bombay, India. He has also served as a volunteer physician under the AMA in Viet Nam. Dr. Johnson recently returned from the U.S.S.R. in a Health Exchange program. Presently, he is plastic surgery consultant to the Sumner Koch Burn Unit at Cook County Hospital and also clinical associate on the staff of the Rockford School of Medicine. He has been a life-long ski enthusiast.



BY ROBERT R. HARTMAN, M.D./JACKSONVILLE

Maternal death study

Case report No. 1

The first in a series of case reports

ONE OF THE FUNCTIONS of the ISMS Committee on Maternal Welfare is to analyze the causes of deaths in Illinois mothers and to determine, if possible, what alterations in management and treatment could have prevented any of these deaths. Each month a case will be presented and discussed in an attempt to promote more modern methods of obstetrical management.

Case Report:

This patient, a 25-year-old gravida V para IV, was admitted to the hospital in early labor on the approximate estimated date of confinement. Her three previous pregnancies, labors, deliveries, and puerperiums had been uncomplicated. She was known to be Rh negative. None of her children had shown evidence of erythroblastosis. Husband's Rh type not known.

The patient was admitted with the statement that for the past two hours she had been having contractions occurring 3-5 minutes apart. She was examined by the nurse in charge and found to have a thick cervix which was 2 cm. dilated, the presenting part was said to be floating. Contractions were described as irregular and of varying quality and intensity. The patient was given an enema plus 1½ grains of Seconal. Three hours later she was complaining rather bitterly about her contractions which were now occurring every two minutes. The cervix was thinner. The head had come down to minus one station. Dilatation was estimated to be 3 cm.

One hour later she was given "Mepergan 50." The bladder appeared to be distended, and at the time of catheterization excessive, bright red

vaginal bleeding was noted. The attending physician came to the hospital and ruptured the membranes, and approximately one hour later she delivered an eight pound male infant in good condition. The placenta was expressed five minutes after the delivery of the baby. Although the uterus seemed to be firm, bleeding was noted to be "excessive." Following one cc. of Ergometrine intramuscularly, bleeding "slowed down" and the patient was taken to her room.

Thirty minutes later the patient was found to be pale, perspiring and confused. She had vomited, and the blood pressure was obtained at 50/0. A large amount of bleeding had occurred—"bed filled with clots." A cut down was instituted approximately 15 minutes later, and the patient was started on 1000 ccs. of normal saline. Typing and cross-matching for one unit of blood was ordered. She expired approximately three hours postpartum with blood still being given. Autopsy revealed a rupture of the uterus extending from the cervix along the left lateral wall with hemorrhage into the retroperitoneal area and desecting of the left lateral wall of the pelvis.

Maternal death study

Your committee felt that this case contained certain preventable aspects:

- A. Occurrence of unexplained excessive bright red bleeding should have alerted the obstetrician that an emergency might be encountered. At this point blood should be cross-matched. This is doubly urgent in dealing with a type of blood which may be difficult to secure easily.
- B. There is no note in the record that any effort was made to attempt to discover the source of the bleeding. An 8 cm. rent in the lateral surface of the uterus should be easily palpable to the examining intrauterine hand, and routine inspection of the cervix should certainly have revealed the presence of laceration. The patient did not expire until more than three hours after delivery, certainly an adequate

length of time to have instituted definitive therapy.

- C. When the need is great, blood should be given rapidly, under pressure.
- D. No mention was made of the type of observation accorded this patient. It seems almost prima facie evidence of neglect that a patient should be found in a bed full of clots less than an hour after delivery. Close observation during the so-called fourth stage of labor is essential in good obstetrical management.

ROBERT R. HARTMAN, M.D., is an obstetrician-gynecologist in Jacksonville and chairman of the ISMS Committee on Maternal Welfare. He received his M.D. degree from Northwestern University Medical School.



OB-GYN Association offers annual awards

- 1. The Central Association of Obstetricians and Gynecologists offers annual awards, totaling \$1,500.00, for outstanding investigative or clinical work in the field of Obstetrics and Gynecology.
- 2. Those eligible to compete are accredited physicians, teachers, research workers and medical students whose work was done within the geographic area of the Association (Alabama, Arizona, Arkansas, Colorado, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin and Wyoming).
- 3. Papers must be written expressly for this competition, and they must be original, not having been previously presented or published.
- 4. Manuscripts, in triplicate, must be submitted

to the Secretary not later than May 1, 1972. The author's identity shall not show on any of the three copies, the only identification being a covering letter and an abstract not to exceed 150 words. The abstract should show the authors as they would appear on the published paper.

- 5. The Annual Prize Award of \$1,000.00 and a Certificate of Merit Award of \$500.00 will be presented to the two successful authors at the annual meeting of the Association. These papers shall be presented by the essayists as part of the Scientific Program at the Annual Meeting, September 21, 22, and 23, 1972, at Stouffer's Riverfront Inn, St. Louis, Missouri. The papers will be offered for publication to the **American Journal of Obstetrics and Gynecology** with the scientific proceedings of the Association. For further details, write Secretary, Clifford P. Goplerud, M.D., University Hospitals, Iowa City, Iowa 52240.

BY MAX S. SADOVE, M.D., MORTON SHULMAN, M.D.,
AND CHARLES BOMBERGER, C.R.N.A./CHICAGO

Comparative study of— Myfadol and meperidine as postoperative analgesics

A NEW ANALGESIC AGENT, myfadol*, was compared against meperidine in 60 post-operative surgical patients on a double-blind basis. Myfadol in doses of 0.5 mg/kg and 1.0 mg/kg proved to be equally as effective as meperidine at a dose of 1.0 mg/kg in controlling postoperative pain. The respiratory and circulatory effects of both drugs were similar and were not remarkable in the doses that were used. Side effects from myfadol appeared to be slightly less than those produced by meperidine. If myfadol turns out to be a truly non-narcotic analgesic, then it should represent a significant advance in the area of pain control.

For some time now a search has been under way for a good non-narcotic analgesic. Although the opiates as a group are good analgesics, they possess the twin liabilities of tolerance and addiction. Those non-narcotic analgesics that are available today are usually of limited potency in that they are effective against mild pain but are often ineffective against severe pain. Although the addiction liability of some of these drugs that are not classified as narcotics is quite low, nevertheless, abuse of these drugs has occurred³⁻⁵ so that one begins to feel that almost any drug which can affect the central nervous system is capable of being abused. However, if a potent analgesic could be found which has, in addition to its analgesia, a low liability for being abused, this drug would represent a significant improvement over many of our present-day analgesics.

The drug, myfadol [F16-I], was originally synthesized and tested in Japan. Studies by Hatano at Nagasaki University showed this drug to be a potent analgesic with a low incidence of side-effects.⁵ Myfadol, in doses of 16 and 24 mg/kg, does not block the withdrawal syndrome in morphine addicted monkeys, nor does it prevent

spontaneous blinking in normal monkeys,⁴ thus indicating that it may have a low order of addictive liability.

The purpose of this study was to compare myfadol and meperidine in a double-blind manner to assess their relative effectiveness in post-operative pain.

Materials and Methods

Sixty adult surgical patients were selected for this study. All of the patients were in the Recovery Room phase of their post-operative care and had signed informed consents concerning participation in this study prior to surgery. Age, sex and race distribution are shown in Table I. Table II shows the types of surgical procedures that were performed on these patients.

Observations were made on all patients for pain, and the pain was assessed according to the judgment of the observer and classified according to the following schedule: 0 = no pain; 1 = mild pain; 2 = moderate pain, and 3 =

*This is an investigative drug made available by A. H. Robins, Richmond, Va.

Postoperative analgesics

severe pain. Only patients with a pain score of 2 or greater were included in the study. Sedation was scored on a scale similar to that used for pain. In addition, measurements were made of arterial blood pressure by the auscultatory method, pulse rate, respiratory rate and respiratory

minute volume. The latter was measured with a Wright spirometer. An arterial blood sample was drawn, and arterial oxygen tensions and carbon dioxide tensions were measured using a Clark electrode and a Severinghaus electrode respectively.

Once control measurements had been made, each patient received intramuscularly either meperidine [1.0 mg/kg], myfadol [0.5 mg/kg], or myfadol [1.0 mg/kg]. Twenty patients received each drug and the schedule of administration of each drug was on a random double-blind basis. Following administration of each drug the same observations and measurements that were made during the control period were repeated at 15, 30, 45, 60, 120 and 180 minutes. Arterial blood gas samples were repeated at 60 and 120 minutes. Side effects were noted and recorded when they occurred. All observations and measurements were made by the same person.

Results

The effect of the two doses of myfadol and one dose of meperidine on pain scores can be seen in Figure 2. Peak analgesic response appeared to be similar for all three drug groups. Although myfadol [0.5 mg/kg] appeared to show less analgesia than the other two drug groups at the 15 minute sampling period, this difference was not significant at the 5% level. All of the patients studied had some degree of pain relief with complete relief of pain occurring in 12 of the 0.5 mg/kg myfadol group, 13 of the 1.0 mg/kg myfadol group and 15 of the 1.0 mg/kg meperidine group.

Similar degrees of sedation occurred in all three groups (Fig. 3). Only two patients developed sedation scores of three and these were both in the meperidine group. Differences between the means of sedation scores of the three groups, however, were not significant at the five percent level.

Changes in arterial blood pressure, pulse rate, respiratory rate and respiratory minute volume were minimal in each group following drug injection (Figs. 4-6). Changes in arterial oxygen and carbon dioxide tensions can be seen in Tables IV and V respectively. It can readily be seen that none of the drugs studied had much effect on arterial blood gas tensions. This correlates well with the minimal changes that were seen in respiratory rate and minute volume.

Side effects were noticed in all three study

Table I
Age, Sex, Race Distribution

Age Group	White		Negro		Total	
	Male	Female	Male	Female	Male	Female
GROUP A—MYFADOL 0.5 mg/kg						
12-17						
18-39		4		2	0	6
40-64	3	4	1	4	4	8
65 & Over	1	1			1	1
GROUP B—MYFADOL 1.0 mg/kg						
12-17						
18-39		2	2	3	2	5
40-64		3		8		11
65 & Over			1	1	1	1
GROUP C—MEPERIDINE 1.0 mg/kg						
12-17						
18-39	2	3		3	2	6
40-64	1	3	1	3	2	6
65 & Over	2	1		1	2	2

Table II

Distribution by Type of Surgical Procedure

Type of Surgical Patients	Myfadol 0.5 mg/kg	Myfadol 1.0 mg/kg	Meperidine 1.0 mg/kg
Cholecystectomy	4	2	3
Exploratory laparotomy	-	1	-
Abdominal hysterectomy	3	4	3
Colon resection	-	1	-
Bowel resection	-	1	1
Gastric resection	2	-	1
Exploratory thoracotomy	1	-	-
Radical mastectomy	1	1	-
Breast biopsy	-	2	1
Radical neck dissection	-	1	-
Vaginal hysterectomy	1	3	1
Repair of cystocele	-	-	2
Ventral hernia	-	1	-
Inguinal herniorrhaphy	3	-	5
Spinal fusion	-	1	-
Hip prosthesis	2	2	-
Arthroplasty, hip	-	-	1
Open reduction, femur	2	-	1
Removal of exostosis femur	1	-	-
Arthrotomy	-	-	1
TOTAL	20	20	20

CHEMICAL STRUCTURES

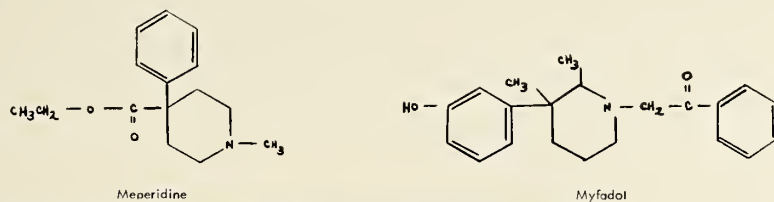


Fig. 1. Structural comparison of myfadol and meperidine

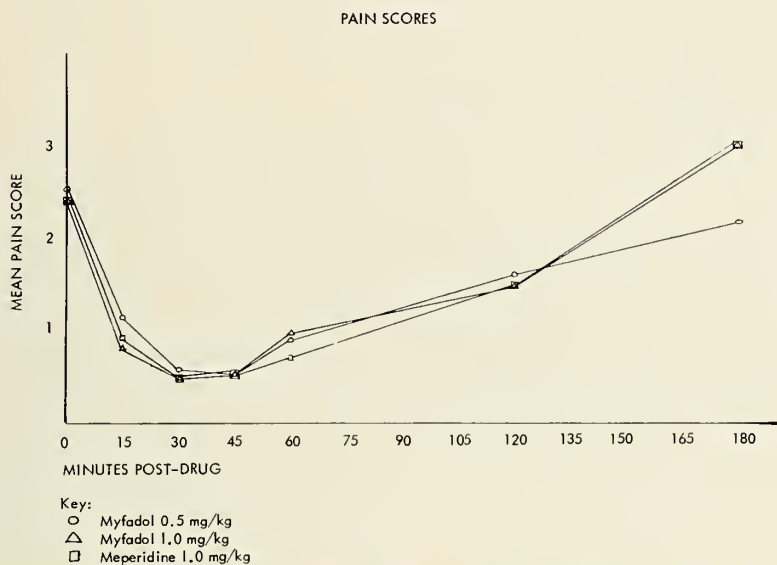


Fig. 2. Mean pain scores following drug injection in each group

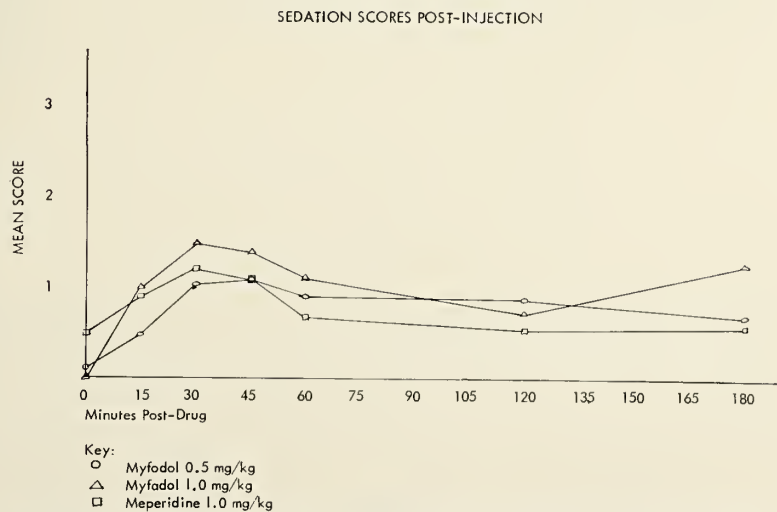


Fig. 3. Mean sedation scores following drug injection in each group

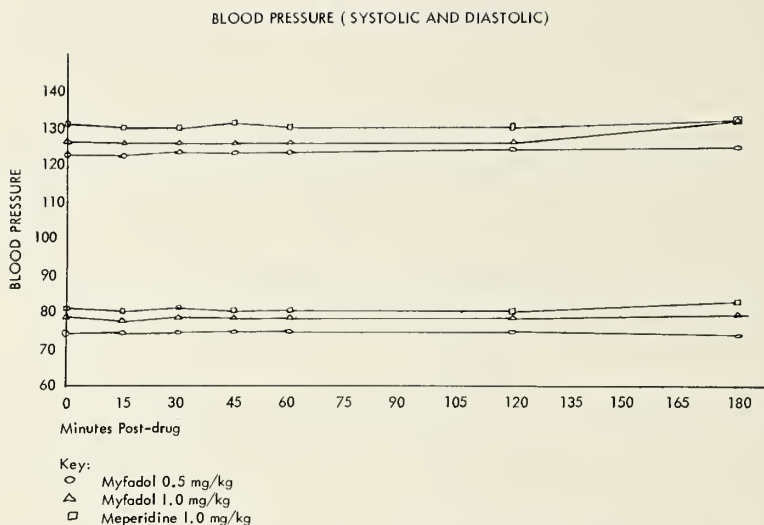


Fig. 4. Mean values for arterial blood pressure in each group

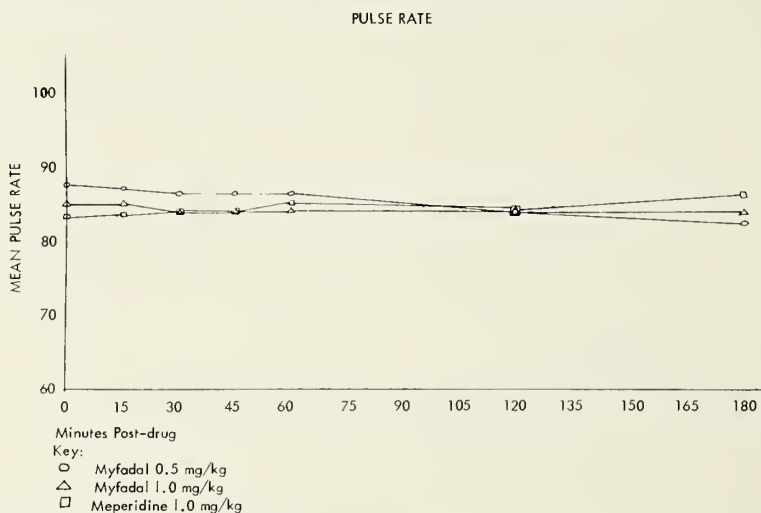


Fig. 5. Mean values for pulse rate in each group

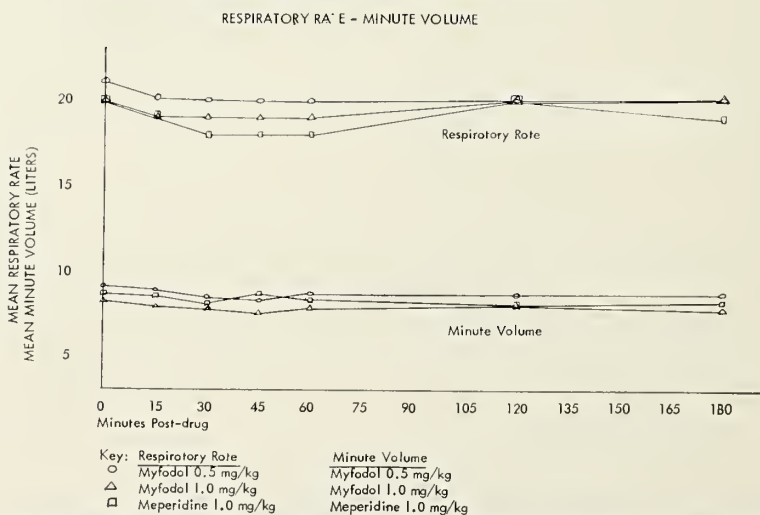


Fig. 6. Mean values for respiratory rate and minute volume in each group

Table III
Side Effects in Each Drug Group

	Myfadol 0.5 mg/kg IM	Myfadol 1.0 mg/kg IM	Meperidine 1.0 mg/kg IM
--	----------------------------	----------------------------	-------------------------------

No. patients with no side effects	7	11	6
No. patients with:			
Nausea	5	4	9
Vomiting	1	0	1
Headache	1	1	0
General Warmth	1	3	4
Dizziness	0	2	0
Blurred Vision	1	1	0
Sweating	3	3	6
Euphoria	0	2	0
Incoordination	0	0	1
Yawning	3	2	0
Total Side Effects	15	18	21

groups. Thirteen patients in the 0.5 mg/kg myfadol group had side effects. Nine patients in the 1.0 mg/kg myfadol group had side effects and 14 patients in the meperidine group had side effects. The types of side effects present in each group can be seen in Table III. It is noted that total side effects were greater in the meperidine group than in either of the myfadol groups.

Discussion

Based on results obtained from a small number of patients, myfadol appears to be very similar to meperidine in its ability to control post-operative pain. Its effect on respiration and circulation also appear to be similar to those of meperidine. The sedative effects of this drug may be somewhat less than those of meperidine as evidenced by the fact that severe degrees of sedation occurred only in the meperidine study group and in neither of the myfadol study groups. Side effects from myfadol also appear to be somewhat less than those from meperidine.

Table IV
Mean Values for Arterial Oxygen Tension

Drug	PO ₂		
	0	Minutes 60	Post-Drug 120

Myfadol 0.5 mg/kg			
# Subjects Evaluated	20	20	19
Mean Value	80	86	89
Myfadol 1.0 mg/kg			
# Subjects Evaluated	20	20	20
Mean Value	84	88	91
Meperidine 1.0 mg/kg			
# Subjects Evaluated	20	20	19
Mean Value	83	86	93

Table V
Mean Values for Arterial Carbon Dioxide Tension

Drug	PCO ₂		
	0	Minutes 60	Post-Drug 120

Myfadol 0.5 mg/kg			
# Subjects Evaluated	20	20	19
Mean Value	28	27	26
Myfadol 1.0 mg/kg			
# Subjects Evaluated	20	20	20
Mean Value	28	26	26
Meperidine 1.0 mg/kg			
# Subjects Evaluated	20	20	19
Mean Value	30	28	26

Thus, myfadol appears to be an analgesic agent that is sufficiently potent to control post-operative pain and that compares favorably to an analgesic that is commonly used for this purpose. It also appears to be able to produce good analgesia without paying too high a price in terms of respiratory, circulatory and central nervous system depression. If, in further studies,

(Continued on page 300)

MORTON SHULMAN, M.D., (not shown) is a clinical-associate professor of anesthesiology at the U. of Illinois Abraham Lincoln School of Medicine, and attending anesthesiologist at Illinois Masonic, U. of Illinois Hospitals, Hines Veterans and West Side Veterans Administrations Hospitals. Dr. Shulman is the author of numerous articles in his field. He received his M.D. degree from the University of Illinois College of Medicine.



MAX S. SADOVE, M.D., (left) is chairman of the Department of Anesthesiology at Rush-Presbyterian-St. Luke's Hospital, and professor and chairman of the Department of Anesthesiology at Rush Medical College. Dr. Sadove serves as a consultant in anesthesiology to a number of hospitals and groups, in addition to being a frequent contributor to medical journals and books. He also holds membership in numerous medical organizations and an extensive list of film and medical exhibit credits. Dr. Sadove received his M.D. degree from the University of Maryland Medical School.

CHARLES BOMBERGER, C.R.N.A., (not shown) was a nurse anesthetist in the University of Illinois Hospitals, and is now a medical student.

Diabetic retinopathy becoming "Public Eye Enemy No. 1"

The appalling number of Americans forecast to be blinded by the eye disease diabetic retinopathy, and the measures being taken to counteract that forecast were the central issues at a recent symposium sponsored by the National Society for the Prevention of Blindness. *Ironic-ally this disease, which is also predicted to overtake cataract and glaucoma to become the leading cause of blindness in the coming decade, is virtually unknown outside certain medical specialties.*

The dual goal of the symposium was to provide a forum for the exchange of views of those physicians prominently involved in research in, and treatment of, diabetic retinopathy; and to point up the urgent need to attract further professional as well as public interest necessary to secure funds for a full-scale research investigation. Fast becoming a major public health problem, diabetic retinopathy currently receives negligible research funding. Six ophthalmologists and two diabetologists (diabetes specialists) participated in the meeting.

Scope of the problem

Richard A. Field, M.D., diabetologist with The Retina Foundation of Boston, and associate clinical professor of medicine, Harvard Medical School, presented a statistical projection of the incidence of diabetic retinopathy, a study prepared in September 1971, by the Harvard School of Public Health.

The study estimates that compared to the current 154,700 persons blind from diabetic retinopathy, by the year 2000 a staggering 573,500 will be blind or severely visually impaired by the disease—more than the number blind from all causes today. (This figure is based on the assumption of a 9% yearly increase in the number of American diabetics, a percentage which has prevailed from 1958 to 1966.)

The National Society for the Prevention of Blindness, in background materials presented at the symposium, noted that current studies estimate that 50% of diabetics who have had diabetes for 20 years will develop retinopathy, blood vessel disease of the eye's retina; as will 95% of them who have lived with diabetes for 30 years. The Society emphasized that there is no cure for diabetic retinopathy, a disease classified into progressive stages—the last being blindness.

Further, current therapy must still be considered "stop-gap" and "experimental," as corroborated by the symposium participants.

Society materials, in calling diabetic retinopathy a major public health problem, pointed out that there are an estimated six million diabetics in the U.S. today; that nearly one person in 20 is either an actual or potential diabetic; and that one-fifth of the population are "carriers," and have a 50% chance of passing the trait on to their children, though they themselves do not develop the disease.

Broad attack

Symposium speaker Charles L. Schepens, M.D., president of The Retina Foundation and associate clinical professor of ophthalmology, Harvard Medical School, stressed that the problem of blindness due to diabetic retinopathy must be met by "a broad attack by many institutions, many teams." And, he advocated, "there should be more and better centers organized to diagnose and treat diabetic retinopathy. . . . Knowledge of such therapy as is currently available should be disseminated." He said that current treatment centers on photocoagulation, in which an intense beam of light is used to "spot weld" the blood vessels of the eye to keep them from hemorrhaging; and suppression of the pituitary, the body's "master gland."

As for future direction, Dr. Schepens urged that improvements in diagnostic methods be undertaken, advocating further development of techniques for photographing the entire interior of the eye; the use of monochromatic light to study the vitreous (the gelatinous substance filling the back portion of the eye); and improvements in reflectometry, the measuring of light wave reflections from inside the eye, to determine oxygen consumption by the retina.

"Oxygen consumption by the retina (the innermost lining of the eye, formed of sensitive nerve cells and fibers), we think, is a major factor in diabetic retinopathy," said Dr. Schepens.

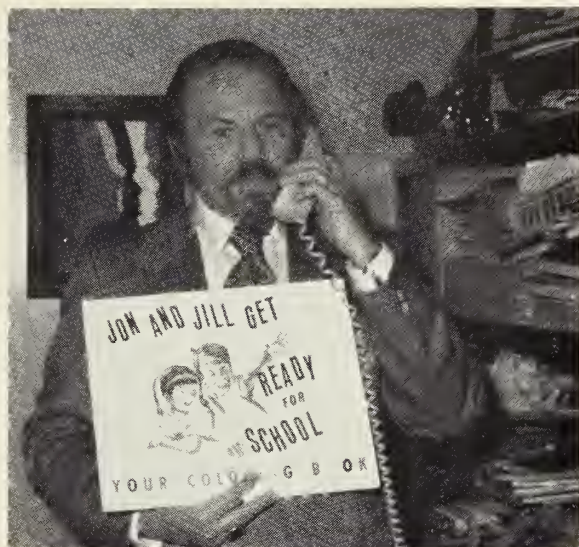
"In terms of dollars," said Dr. Schepens, "I would suggest an immediate rock-bottom goal of \$4.6 million, for training and research related to diabetic retinopathy." HEW's National Eye Institute, one of the National Institutes of Health, has allocated \$1.28 million for diabetic retinopathy research for the current fiscal year.

*Take one allergist....
an idea.....*

and a publisher

The result?

A READ-ORING BOOK!



A new approach to juvenile health education

“YOU’VE DONE what many of us have thought about doing. . . .” has a familiar ring whenever Dr Robert Becker, a Joliet allergist, happens to be among his physician-peers.

What Dr. Becker has done and is continuing to do is publish a new concept in juvenile health education—GET READY FOR. . . READ-ORING BOOKS.

JON AND JILL GET READY FOR SCHOOL is the first of what Dr. Becker hopes will be a series of books designed specifically for the pre-school and early-school age groups on health education.

Recognizing that all health education implementation has been at the high school and adult levels, Dr. Becker decided to set his ideas and those of his colleagues into a form acceptable to this juvenile age group.

“Anyone knows that learning comes easier to the younger child than to teenagers or adults, whether it be a language or reading,” Dr. Becker explained. “I decided to market a product that would make the learning process an enjoyable

experience, and one with which children could identify. This type of book—which can be colored or read—makes children feel it belongs to them.”

Idea takes hold

In describing how the idea for such a book took hold, Dr. Becker explained that he had observed in his practice that the most cooperative patient was one the parents had spent time with, preparing for an experience such as a visit to the doctor’s office.

“One of the problems of the present relationship between parent and child is the failure of the parent to assume parental responsibilities,” Dr. Becker said.

He went on to explain that the affluence which has enveloped many of us, the pace of today’s society, which has changed the goals of most parents, and the media, have all contributed to the “gulf” in the parent-child relationship. Even those parents who want to exert responsibility toward their children lack the adequate instruments to do so, Dr. Becker pointed out.

One such instrument is adequate material which prepares parents who in turn prepare their children for such experiences as pre-school health exams and sex information.

JON AND JILL GET READY FOR SCHOOL is a 14x11 inch coloring book based on Dr. Becker’s experience as both a father and physician. Dr. Becker wrote the copy and planned the layout, while a commercial artist drew the illustrations. Rather than follow the usual route of marketing the book and then publishing it, Dr. Becker chose the more challenging one—publishing the book and then marketing it.

Finding a publisher

“I presented the books to drug companies and various publishers, such as Western Publishing who handles GOLDEN BOOKS for children, but they didn’t seem to know where such a book would fit in their line,” Dr. Becker explained.

So another channel was devised — the innovation of “THAT Book Company” which Dr. Becker “named” as his publisher.

A READ-ORING BOOK

Considering the entire venture as both an investment and an experience, Dr. Becker's "company" has published 2,000 of the READ-ORING books to date. He projected he would need to publish and sell a total of 4,000 books to break-even on the project. The book is selling for \$1.95 at local bookstores in Joliet, and Dr. Becker revealed that Kroch and Bretano's Bookstore had expressed interest in marketing the book if some outside stimulus created a desire for such an item.

"I have deliberately separated the book from my practice," Dr. Becker went on to explain, "because I don't want my patients to feel obligated to purchase it."

Presently, one drug company is considering "miniaturizing" the book and sending it to pediatricians for their patients, but nothing definite has been decided.

Book well-accepted

Reactions on the book have

varied among the professions, with social workers critical of the absence of ethnic groups, (which incidentally will be corrected in subsequent printings) and some doctors feeling there is too much negativism in the mention of diseases as polio and diphtheria. Dr. Becker, however, feels the most significant evaluation comes from parents and their children, who on the whole have found it a functional and enjoyable product.

While the issue of publishing the books on a wider scale has not yet been remedied, Dr. Becker is currently preparing for the publication of a second book, JON AND JILL GET READY FOR A NEW BABY. This book is expected to determine the future of such a series or the direction Dr. Becker will take. Other possible subjects for such a series would include a book for children of one-parent homes as a result of death or divorce.

A collector of clowns

A massive collection of clowns which line the walls and shelves of Dr. Becker's offices reveal a philosophy he finds applicable in both his practice as a physician and as a writer and publisher of books—"No matter how bad things are, they could always be worse. . . . so wear a smile." And that is exactly what Dr. Becker intends to do as he pursues his own individual campaign for preschool health education material.

Dr. Robert Becker is chairman of the FMC Committee for the Will-Grundy County Medical Society, a delegate to the ISMS House of Delegates, and a delegate to the P.R. Council. In addition, he moderates on a rotating basis, "Doctors Call," a Joliet radio program, and is a member of the Joliet High School Board. He and Mrs. Becker are the parents of three children.

Postoperative analgesics

(Continued from page 297)

this agent proves to be truly non-narcotic, which some of the earlier experimental work might tend to indicate, then myfadol should represent a significant improvement over some of the presently utilized analgesic agents.

References

1. Hatano, S.: "Study of a new analgesic—TA-306," Presented at the Second Asian and Australasian Congress of Anesthesiology, Kyoto, Japan, Sept., 1966.
2. Kugita, H., Oine, T., Inoue, H. and Hayashi, G.: "3-alkyl-3-phenylpiperidine derivatives as analgesics." *J. Med. Chem.*, 8:313-316, May, 1965.
3. Mattson, R. H., Weisman, G. K. and Levy, L. L.: "Dependence and central nervous system toxicity associated with the use of propoxyphine hydrochloride," *Trans. Am. Neurol. Assoc.*, 94:299-301, 1969.
4. Sandavaal, R. G., Wang, R. I.: "Tolerance and dependence on pentazocine," *New Eng. J. Med.*, 280:1391-1392, June 19, 1969.
5. Smith, J. W.: "Drug abuse with pentazocine," *N. West Med.*, 68:1128, Dec., 1969.



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

Duplicate Single Products

AZOLID Antiarthritic (Nonhormonal) R

Manufacturer: USV Pharm

Nonproprietary name: Phenylbutazone

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis

Dosage:

Precautions: } See package insert

Contraindications: }

Supplied: Tablets, 100 mg.

MELTROL Hypoglycemics R

Manufacturer: USV Pharm

Nonproprietary name: Phenformin HCl

Indications: Stable adult diabetes mellitus

Dosage: Oral therapy must be individualized

Supplied: Tablets, 25 mg., 50 mg., and 100 mg.

PRESAMINE Psychostimulants R

Manufacturer: USV Pharm

Nonproprietary name: Imipramine HCl

Indications: Depressive states of diverse psychopathology

Dosage: Adult: Initially 100 mg. daily in divided doses gradually increased to 200 mg. daily as required.

Adolescents and geriatric patients: see package insert.

Supplied: Tablets, 10 mg., 25 mg. and 50 mg.

Combination Products

AZOLID - A Antiarthritic (Nonhormonal) R

Manufacturer: USV Pharm

Composition: Each capsule contains:

Phenylbutazone 100 mg.

Aluminum hydroxide 100 mg.

(dried gel)

Magnesium trisilicate 150 mg.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis

Dosage:

Precautions: } See package insert

Contraindications: }

Supplied: Capsules

TRIHEMIC 600 Hematinics R

Manufacturer: Lederle

Composition: Each tablet contains:

Vitamin C 600 mg.

Vitamin B₁₂ 25 mcg.

Folic Acid 1 mg.

Intrinsic Factor Conc. 75 mg.

Vitamin E 30 Int'l Units

Elemental Iron 115 mg.

Diethyl sodium 50 mg.

sulfosuccinate

Indications: Treatment of most anemias.

Precautions: Check response periodically

Dosage: One tablet daily, adjust to response

Supplied: Tablets

Correction: The manufacturer for **NARCAN** should be Endo Laboratories not Lilly. (January, 1972, *IMJ*, page 78)

New drug discount service for epileptics

The Women's Auxiliary of the Illinois Epilepsy League is pleased to announce that arrangements have been made for a *special drug discount to be obtained on antiepileptic medications purchased at Walgreen Drugstores in Illinois.*

A Drug Discount Membership Card will be supplied on written application with a one dollar donation to the Women's Auxiliary, Illinois Epilepsy League, 343 S. Dearborn Street, Chicago 60604. The donation will be used for the support of research in epilepsy.



practice management

The value of the investment counselor

RICHARD B. CURRIE, SENIOR CONSULTANT
PROFESSIONAL BUSINESS MANAGEMENT, INC.
67 E. Madison Street, Chicago
782-2282

We are living and working in an era of specialization. The specialist in medicine is a familiar figure—the dermatologist, the radiologist, the otologist, the pediatrician, the diagnostician, the psychiatrist. Business has also graduated to the specialist—the public relations man, the expert in labor relations, the whole field of advertising, and even the professional consultant—a specialist in medical business.

The field of investment is no exception to this trend. Here, specialization has developed a relatively new profession—investment counsel. In the past two decades this “infant” has grown into a solid, mature, recognized specialist; a specialist in investments whose only commodity is advice.

Among the many millions of stockholders in this country there are a few strong-minded individuals who want no man's advice on what stocks to buy nor when to sell. The experienced investors, however, know that investment management involves more than reading daily stock market quotations, and that security analysis goes deeper than annual company reports. They seek advice and have no trouble finding it.

The advice givers fall into five main classes:

1. Brokers, who also do your buying and selling;
2. Investment bankers, whose business is marketing securities;
3. Publishers of financial sheets, which range from top-flight to tipster;
4. Trust companies who are usually commercial bankers;
- and 5. Investment counselors. This last advice given is the only one whose interest is identical to the client.

In today's money market, if it is difficult for the investment counselor to keep up with the complexity of each organization whose stock is for sale and it is virtually impossible for the amateur. In the days of your great-grandfather it was easy. He was probably on intimate speaking terms with the officers of the companies he invested in, he knew where their markets were, and he knew who bought the product. He could see what he was putting his money into. He didn't need advice. But that was your great-grandfather! Your great-grandchildren will only be required to push a few buttons. You, unfortunately, need advice!

The broker, the investment banker, the publisher of the financial sheets, and the trust company, are businessmen who are interested in commissions from selling and buying securities. The investment counselor is unbiased. He is not interested in any particular security, only in the financial welfare of his client.

If you have accumulated a considerable portfolio of securities and are attempting to conduct your own investment program, stop and reflect. “Am I really qualified to get the most out of this?” “Am I qualified to see that my portfolio will grow and remain secure?” You may realize that you need advice.

In recent years, because of the growth of medical corporations, the investment counselor has taken on new importance. During the first year or two of corporate practice, your profit-sharing and pension plans are relatively small, and the

management of the funds more or less uncomplicated. But, as the funds accumulate it becomes important that you consider the same question. "Are we (the officer trustees) really qualified to get the most out of this?" "Do we need advice?"

Now we come to the selection of the investment counselor. You may have heard that you must have a substantially large portfolio before the counselor would be interested. This is not necessarily true, although there are firms that are only interested in managing accounts of \$500,000 or more. There are, however, many who are willing to handle less than \$100,000 and many who ask no minimum at all. Because most have an annual fee of about \$5 per \$1000 of assets, with a minimum fee of from \$250 to \$500, the very small investor would find the counsel-

or's advice extremely costly, and would probably be better off in a no-load mutual fund until he had built-up his investment accounts.

The investment counselor who accepts small accounts wants a client with the potential to add to his capital as time goes by. Thus he can be of service to him at an early stage in his investment experience, when his holdings are still comparatively small. In other words, it is not altogether the size of your portfolio, but the potential that you and the counselor should be interested in. The important thing is to pick one that you have confidence in. To this end you might want to write to Investment Counsel Association of America, Inc., 127 East 59th Street, Room 201, New York, New York. They will send you a booklet of all their numbers and you will be able to select one in your area.

"Parenthood Is Fun"—Myth Will Die

The foundation of almost everything else that is occurring in the sphere of marriage and family life today is a process which will go right ahead in the next decade or two, and will continue to have a vast effect on people's thinking and their behavior. This process is what Max Weber called the *entzauberung*, the "demystification" or "disenchantment" of human life, which is a hallmark of the modern orientation. Young people, especially, are continually becoming more sophisticated—due to television, modern education, peer group frankness about all spheres of life, etc.—and they are no longer accepting the myths, the conventional folklore, upon which ordinary social interaction has been based during the past few decades. Thus, for instance, young people are gradually rejecting the myth of "parenthood is fun," realizing that parenthood is a very serious business and one which ought to be undertaken only when people are ready to plunge in and do a good job.

Another grand complex of myths that is gradually being rejected is that of romantic love, under which it is perfectly acceptable to meet a person, form a sudden emotional attachment to that person without any logic or contemplation, and to marry that person on no other basis than the existence of his cathexis. Similarly, the whole institution of "shotgun weddings," in which an unwanted, unintended pregnancy (usually occurring with a lower class girl) leads to what is called "necessary" marriage, is going to become a quaint piece of history which will be considered with the same glee that modern readers feel when they read about "bundling" in Colonial America. With young men and women who are all fully-informed about reproduction and what can be done to prevent it, such things will occur very rarely; romantic mate-selection, likewise, is going to continue only among the impoverished and marginally-educated segment of society. (Leo Davids.: "North American Marriage: 1990," *The Futurist*, Oct., 1971, pgs. 190-194.)

Obituaries

***Absher, Charles O.**, Newton, died Jan. 9, at the age of 78. He was one of four doctors in Jasper County where he established his practice in 1935.

***Alt, Howard L.**, Evanston, died Feb. 12, at age 71. He was a professor of medicine at Northwestern for 41 years. Dr. Alt gained world recognition for research on red blood cell production.

Baittle, Brahm, Chicago, died in January. A Chicago psychiatrist, he served as an assistant professor at the University of Illinois Medical School, as an instructor at Northwestern University Medical School, and as a consultant at the VA Research Hospital.

***Barbour, Ben**, Sara, died Dec. 31, at the age of 60. He had practiced as a physician and surgeon in Sara since 1940.

***Berkwits, Edward**, Chicago, died Jan. 6, at the age of 45. He was medical director of the department of ambulatory services of Grant Hospital and a former instructor in the department of medicine at Northwestern University. He was among the first group of physicians in the nation to be certified as a specialist in family practice by the American Board of Family Practice.

***Bernstein, Leon**, Los Angeles, died Dec. 25, at the age of 49. A former Chicago psychoanalyst, he moved to Los Angeles in 1962.

Breitzer, Bernard, Chicago, died in January.

Brust, Edmund G., McHenry, died Jan. 23, at the age of 78. He practiced medicine in Melrose Park for 50 years, and was a founder and staff member of Westlake Community Hospital there.

Comstock, Frank H., La Grange Park, died in Burbank, July 22, at the age of 73.

Elghammer, H. William, Chicago, died Jan. 25, at the age of 77. He was a pediatrician and former staff professor and chairman of pediatrics at Loyola University's Stritch School of Medicine.

***Epstein, Sidney E.**, Skokie, died Feb. 3, at the age of 55. He was a pediatrician on the hospital research staff of Abbott Laboratories.

Fine, Bernard J., Chicago, died in February.

Gore, George, J. Chicago, died Oct. 24, at the age of 75.

Gunnar, Herman P., Oak Park, died in January at the age of 81. He was on the staff of MacNeal Memorial Hospital and founder of Gunnar Clinic.

***Hartney, James B.**, died Feb. 9, at the age of 51. He was a former ISMS trustee, and director of the Chicago Metropolitan Blood Council and

the Cooperative Blood Replacement Plan. Dr. Hartney was a nationally recognized critic of the paid blood donor system in Chicago.

Hsia, David Yi-yung, Evanston, died Jan. 27, at the age of 46. A noted Chicago pediatrician and expert on hereditary diseases, Dr. Hsia was the developer of a program for detection of phenylketonuria, and was also noted for his research on milk tolerance in infants, infant jaundice and cystic fibrosis. He was chairman of the pediatrics department at Loyola University's Stritch School of Medicine.

Isenberg, Sampson, Chicago, died Jan. 10.

****Jaffe, Joseph**, Chicago, died Jan. 20, at the age of 83. He was a physician for more than 50 years.

***Keeseey, Wilber E.**, Chicago, died Jan. 9, at the age of 72. He was a surgeon on the staff of Illinois Masonic Hospital since 1928.

****Krumm, John F.**, Glen Ellyn, died in January, at the age of 74.

***Lehner, Arthur E.**, Park Ridge, died Dec. 28, at the age of 91. He practiced medicine for more than 50 years and was a long-time staff member of Norwegian American Hospital.

***Lev, Morris W.**, Homewood, died Jan. 11, at the age of 72. He was a retired heart specialist and internist, and had practiced medicine for more than 43 years.

***Meyers, Isadore H.**, Franklin Park, died in January. He was a physician and surgeon in Franklin Park for more than 25 years and was on the staff at DuPage Memorial Hospital.

****Miller, Edwin M., Sr.**, Chicago, died in February, at the age of 83. He was former chief of surgery at Rush-Presbyterian-St. Luke's Hospital.

***Morrison, Allen R.**, Villa Park, died Jan. 27, at the age of 65. He maintained a private practice in Maywood for 30 years and was associate medical director for American Can Co. for 11 years.

***Mulliken, O. Dale**, Elgin, died Dec. 27. He was a physician and surgeon in Elgin for 45 years.

Neilson, William G., Kewanee, died Jan. 7, at the age of 48. He was a member of the Henry County Medical Society.

****Nowakowsky, Sophie**, Chicago, died at the age of 84. She was chief pathologist for the cancer section, division of adult health and aging,

(Continued on page 315)

the peer reviewer

Council on Economics and Peer Review

division of health care delivery

January, 1972

Vol. 2 No. 1

RAISE FOR PEER REVIEW COMMITTEES WAS VOICED BY HOUSE WAYS AND MEANS COMMITTEE CHAIRMAN Wilbur Mills (D-Ark.) at recent hearings on national health insurance. Rep. Mills thought peer review committees, "do a wonderful service," after meeting with a local committee and watching it in action. "I never thought that doctors would talk about each other as they did," he said, and suggested that other members of Congress sit in with peer review committees to see how they work.

ADDITIONS TO ISMS' SUGGESTED PEER REVIEW GUIDELINES FOR LOCAL COMMITTEES WERE prepared by a special sub-committee of the Council and approved by the ISMS Board of Trustees. These additions (a copy is attached) emphasize the Council's stated philosophy that quality care is the prime concern of peer review; that all cases referred for review should be considered regardless of the potential for litigation; and that plans or programs of third party carriers may also be referred to peer review for suggestions or improvements in quality of care. The special sub-committee also made several procedural additions to the guidelines. (See additions on p. 306)

AMA'S HOUSE OF DELEGATES ADOPTED A RESOLUTION URGING ALL HEALTH INSURANCE CARRIERS AND GOVERNMENTAL agencies to rely on peer review to adjudicate all matters concerning the quality, cost and utilization of medical care. The resolution also reaffirmed AMA's position that it is the responsibility of state and county medical societies to create active and effective systems of peer review.

AN UPDATED LIST OF COUNTY SOCIETY PEER REVIEW COMMITTEE MEMBERS IS BEING REQUESTED BY ISMS from each County Society Secretary. Membership on local committees changes and a current list is necessary so the state can refer cases directly to the appropriate county peer review mechanism. This information is also needed by ISMS to provide helpful materials designed to assist local committees in their important peer review activities.

ADDITIONS TO PEER REVIEW GUIDELINES

The sub-committee emphasizes the stated philosophy of the Peer Review Council in that:

1. Quality care is the prime concern of Peer Review
2. All cases referred for review should be considered regardless of the potential for litigation
3. Plans or programs of third party carriers may also be referred to ISMS Peer Review for suggestions or improvement in quality of care

This sub-committee also suggests the following procedural additions to the ISMS Peer Review Guidelines:

If dollar limitations are to be delineated, we suggest some such limits as:

A. Initiated by patient: \$25

B. Initiated by carrier: \$100

Carriers to be charged for staff time for processing in inverse proportion to dollar amount of claim as follows:

\$30 for \$100-199 claim

\$25 " \$200-499 "

\$20 " \$500-750 "

\$15 " \$750 or more claim.

C. Initiated by physician: None.

D. Initiated by peer review committee: None.

Third party fee profile data furnished by the carrier should include: number of said procedures, fee range as billed by physician and as paid by carrier for the year in question.

One postponement of hearing, with two weeks notice prior to meeting date, is possible if one party involved is unable to be present.

LOCAL COUNTY PEER REVIEW COMMITTEES ARE URGED TO ORDER A COPY OF AMA'S RECENTLY PUBLISHED PEER REVIEW MANUAL. This comprehensive two-volume manual, selling for \$4.00, is highly informative and offers a compilation of the development and operation of a peer review program. Local peer review committees will find the manuals very helpful in all facets of peer review activities as well as providing excellent examples of cases and reference materials. A convenient order blank appears below. Please complete the form and return to ISMS' offices with a check as soon as possible. Your copy will be on its way to you immediately upon receipt of the order.

Please ship _____ copy(ies) of the AMA PEER REVIEW MANUAL at a cost of \$4.00 each. A check for \$ _____ is enclosed. (Make check payable to American Medical Association)

_____ COUNTY MEDICAL SOCIETY
Send to: _____ Street
_____ City & State
_____ Zip Code
_____ M.D.,
Peer Review Chairman

RETURN ORDER FORM AND CHECK TO ILLINOIS STATE MEDICAL SOCIETY, 360
1. MICHIGAN AVENUE, CHICAGO, ILLINOIS 60601.

Physicians must make schedules of fees available

Phase 2 Controls require physicians to maintain schedules of the fees for their principal services and to post a sign stating the availability and location of the schedule. There has been considerable misunderstanding of this regulation. The regulation does not say that a physician must post his fees. He must keep a list of his principal charges during the period between Aug. 16 and Nov. 13, 1971, and the list

must show any changes made in the fees since Nov. 14, 1971. The sign stating the availability and location of the fee list must be posed in a prominent place. Although the regulations for institutional providers call for a 22" x 28" sign, the regulations do not specify the size of the sign to be posted by non-institutional providers. The sign to be posted by physicians should be large enough to be in reasonable compliance with the intent of the regulations.

Abstracts of Board actions

(Continued from page 252)

The Board concurred that physicians should consider the advisability of routinely checking patients for rubella immunity and that the test for rubella immunity should become an essential part of every patient's pre-marital or initial pregnancy work-up.

Liaison with Medical Schools

The Board authorized formation of a joint committee representing the Council of Medical School Deans, the ISMS Council on Education and Manpower and the Governmental Affairs Council so that mutually satisfactory approaches can be developed on education, legislation and other matters. The deans also will be informed that—should they desire ISMS support of their budgetary needs—they have access to our Council on Governmental Affairs.

Physician's Assistants

Unable to agree on the language of the proposed enabling legislation for physician's assistants, the Board of Trustees directed its Ad Hoc Committee on Physician's Assistants to develop a resolution on this subject for presentation to the House of Delegates.

Student Visitation Program

The Board referred to the Task Force on Physician Shortage a proposal by the Alumni Association of the University of Illinois College of Medicine for medical student familiarization with practice in Illinois. Aim of the program is to provide medical students with broad opportunities to examine the many ways in which medicine is practiced in the state by asking physicians to provide lodging, meals, transportation or other subsidy to encourage students to make short visits to their communities.

Recommendations of the Governmental Affairs Council

The Board approved the following recommendations of the Governmental Affairs Council:

1. If the Illinois Association of Ophthalmology files an appeal in the court case which the Department of Registration and Education has pending against the House of Vision for practicing optometry without a license by fitting contact lenses, ISMS should join the Illinois Association of Ophthalmology in filing a brief as a friend of the court.
2. That ISMS endorse third party reimbursement for appliances and services which have been ordered in writing by physicians licensed to practice medicine in all its branches.
3. That ISMS take no position in the Osco Drug Company dispute with the Illinois Pharmaceutical Association and the Department of Registration and Education. The Association had requested ISMS to support its case against Osco pharmacists advertising reduced drug prices.
4. That HB 2222, mandatory reporting of lead poisoning, be supported.
5. That HB 971-973, psychologist reimbursement bills, be supported in principle, provided the services are ordered by a physician licensed to practice medicine in all its branches.

Department of Public Aid Medical Advisory Board

To give physicians throughout the state an opportunity to bring their complaints to the Department of Public Aid and to give the Department an opportunity to discuss its problems directly with physicians, a series of meetings are being scheduled by the Department's Medical Advisory Committee in various parts of the state. The first meeting will be February 26, in Alton.

Illinois Pharmaceutical Association

The Board rejected an Ad Hoc Committee recommendation to support the Illinois Pharmaceutical Association in its efforts to amend Section 3.14 (Anti-substitution Statute) of the Illinois Food, Drug and Cosmetic Act. IPhA's proposed amendment would give pharmacists more latitude in substituting prescribed drugs. Also defeated was a motion to support IPhA efforts in amending the drug labeling laws permitting use of non-proprietary names on prescription labels.

However, the Board did approve recommendations to direct the ISMS Drugs and Therapeutics Committee to work with IPhA in developing a Code of Understanding and explore a mutually agreeable procedure of brand selection. It also approved ISMS support of an amendment to drug labeling laws to allow physicians to give verbal authorization to pharmacists not to identify contents of prescription drugs.

Board to Respond to Dr. Haughton's Testimony

The board voted to object, through the Cook County Health and Hospitals Governing Commission, to the widely-publicized testimony which Dr. James G. Haughton, its Executive Director, presented January 12, to the Policy Council of the Democratic National Committee. The testimony included heavy-handed criticism of fee-for-service health care. It also implied that all doctors compete for the right to treat illnesses at the highest fee the traffic will bear; that surgeons operate unnecessarily; and psychiatrists provide therapy as long as patients are willing to pay for it.

Memorial Resolution for Timothy D. Selleck

The Board adopted a memorial resolution for Timothy D. Selleck, director of the ISMS Governmental Affairs Division, who was killed October 21, 1971 in an airplane crash in Peoria.

Illinois Admits 23 Board Recommended Students

The University of Illinois Medical School has accepted for admission next fall 23 students recommended by the ISMS-IAA Student Loan Fund Board. This is the largest number ever accepted on recommendation of the Board. The students come from 21 different counties in Illinois.

U. S. Students from Foreign Medical Schools

The Board authorized the Council on Education and Manpower to prepare appropriate resolutions for the ISMS House of Delegates and for the AMA House to allow American students from foreign medical schools to enter U.S. schools with advanced standing, with the level to be determined by qualitative testing. Present AMA policy only allows such students to be admitted to externships in the United States.

WANTED: Medical memorabilia

Southern Illinois University School of Medicine, Springfield, has started an historic medical museum and is anxious to acquire the following: medical tools and artifacts; documents; day books; drugs; bottles; bags; biographies; paintings; photographs; and books up to the 20th century.

Contact the Curator, Southern Illinois University Medical Museum, 421 S. 6th St., Springfield, Ill. 62704.

When you prescribed Orinase®

(tolbutamide, Upjohn)

14 years ago,
you had to rely on
our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated fetocidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions; how to develop a careful attitude and disregard instructions relating to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; when to use insulin; and to report to the physician immediately when he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the period in order to avoid ketosis, acidosis, and coma; when diuretics are administered which may result in aggravation of the diabetic state and increased tolbutamide requirement, thereby loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or adjustment of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, contraindications, and selection of patients for therapy.

Patients must be under continuous medical supervision during the initial test period should communicate with the physician.

Today you have your own.

If you're around 40 or 45, you've probably had quite a bit of clinical experience with Orinase.

Maybe as much as 14 years.

And that means you know quite a bit about it.

On the one hand, you know that diet and weight control are the initial and essential foundations for the management of adult-onset, non-ketotic diabetes. When these measures prove satisfactory, no additional therapy is indicated. On the other hand, you know that if these measures fail the addition

of Orinase to the regimen can often help lower blood sugar. Orinase lowers blood sugar as effectively today as it did when you first prescribed it.

You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

In short, Orinase is a drug you're familiar with, and probably have confidence in.

And that may be the best recommendation Orinase can have.

Orinase[®] 0.5 g. tablets (tolbutamide, Upjohn)

daily, and during the first month report at least once weekly physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory fasting or persistent elevation of blood sugar, or failure to maintain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

Phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and pyrimidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without pro-

ducing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

Supplied: 0.5 g. Tablets—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

For additional product information, see your Upjohn representative or consult the package insert.

The Upjohn Company, Kalamazoo, Michigan 49001

Upjohn



report

a service of the american association of medical assistants, illinois society

Illinois Society annual meeting set for April

More than 300 medical assistants from throughout the state will gather at the Gurnee Holiday Inn in April for the 16th annual meeting of the Illinois Society, American Association of Medical Assistants.

The meeting begins Friday, April 21 and ends Sunday, April 23, 1972.

Highlights include professional education programs, a session of the House of Delegates and installation of officers, according to Mrs. Zelma Bechtol, Lake Villa, convention chairman.

Educational sessions will begin Saturday morning with a panel discussing three phases of medicine.

Speakers and their topics are Dr. Eugene Scheimann, Chicago, syndicated columnist *Chicago Today*, "Palmistry and Astrology;" Don Frey, Chicago, executive director, Health Careers Council of Illinois, "Health Careers;" and Fred French, administrator, Suburban Heights Medical Center, West Chicago, "Administration of a Clinic."

Dr. Frank J. Jirka, Jr. of River Forest, president, Illinois State Medical Society, will be the featured speaker during the Saturday awards luncheon.

"Missionary Medicine and Surgery" will be the late afternoon topic of a discussion and slide presentation by Dr. Burt Long, Niger, West Africa. Dr. Long is a missionary surgeon.

Saturday evening Mrs. June Hall, Danville, will be installed as president of the 650-member organization. The speaker will be Dr. Paul Williamson, Macomb, Mississippi, editor of *Practice*.

The meeting will close with a Sunday morning breakfast when Mrs. Adele Kweder, Waukegan, past president, Illinois State Medical Society Women's Auxiliary, will address the medical assistants.

The Illinois Society, American Association of Medical Assistants is an educational non-profit organization designed to maintain high professional standards among medical secretaries, nurses and technicians.

The human factor in medical assisting

Psychologists say that the most productive working condition is wherever work can be accomplished without danger of interruption. There are exceptions to every rule and the exception to this one is any medical office on any given day. Occasionally it is possible to work behind a closed door for a short period of time but usually this produces a backlog of phone calls which must be returned at a later time.

In the medical office there are no "DO NOT DISTURB" signs no matter how full the schedule. Most often it is the medical assistant who answers the phone, receives and prepares the patient, collects the fee, or sends the bill, and may be with the patient for longer periods of time than the physician.

The medical assistant can further help her employer by realizing people react differently under stress of illness and she must develop a rapport with them. The "tender, loving care technique" is not to be overlooked but there are other ways to indicate understanding and an interest in the patient's problem and feelings.

Illinois Society offers seminars on human relations as well as effective public speaking to help your medical assistant become proficient in projecting the human factor in your office.

For further information regarding Illinois Society, American Association of Medical Assistants contact Mrs. Norma Domanic, 150 Ash Street, New Lenox, Illinois 60451 or Mrs. Vivian Kraft, R.R. #2, Normal, Illinois 61761.

Dimetapp Extentabs®

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Obituaries

(Continued from page 304)

Chicago Board of Health, and taught at Chicago Medical School.

***Sadauskas, Jonas**, Decatur, died Jan. 12, at the age of 57.

***Sadowski, Frank**, died in February at age 83.

****Schorr, Henry C.**, Chicago, died Jan. 13, at the age of 79. He was a physician for more than 50 years and a faculty member of the University of Illinois Research Medical School for the last 20 years.

Sheinin, John J., Chicago, died in January at the age of 71. He was president emeritus of Chicago Medical School, and was instrumental in keeping the school open when it did not have the approval of the AMA or the Association of American Medical Colleges.

***Stollar, Clyde P.**, Park Ridge, died Dec. 31, at the age of 76.

***Simon, Oliver B.**, Batavia, died Dec. 3, at the age of 77. He had practiced medicine for more than 54 years and had been health officer for Batavia for 36 years.

Teder, Richard T., died in January.

Thomson, Stewart C., Byron, died Jan. 21, at the age of 66.

Weber, Gerald W., Arlington Heights, died in January.

***Wippert, Virgil**, Chicago, died Jan. 19, at the age of 70. He was senior staff member of St. George's Hospital and had been associated with it since its founding.

**Denotes ISMS member*

***Denotes Fifty-Year Club member and ISMS member*

Wine-and-health awards announced

The 1972 contest recognizing outstanding communications about wine-and-health has just been announced.

One thousand dollar prizes will be awarded in three categories for works which tell of the health aspects of wine and appear during the year 1972.

The prizes will be awarded for articles published in public newspapers and magazines, in medical publications, and for radio-television broadcasts.

Deadline for submission of entries is January 31, 1973.

Details of the contest are available from the Administrator, Wine & Health Writing Awards, 2729 W. Lunt Ave., Chicago, Ill. 60645.



From your president.....

BY LIVIA MARTINUCCI
WA/ISMS PRESIDENT

I ACCEPT THIS office with feelings of pride—pride in this organization and what it stands for, and honest pride in the fact that you chose me to be your president. My observation over the years with community involvement show no other group comes close to the auxiliary in friendships given and services and opportunities freely offered to others. It is a unique organization of women bound together by their relationship to a gifted group of men.

We live in a group centered culture. Our Auxiliary was founded on the concept of the value of group activity, of working with others. Then, as now, there was the realization that health is a joint endeavor. The doctors understand the need to administer not only to the human body and its ills but also to the human hearts, minds and emotion. Therefore this year our theme will be to appreciate the individual—and—"to get to know you."

This, then, is the area in which we can move forward. We can "get to know" ourselves, and our families, other physicians' families, and our communities. Dr. Menninger of the Menninger Clinic defines maturity as "the capacity to love, to care about other people in the broadest sense, and continue to increase this capacity beyond our families to the community—to the state—to the nation—and to the shrinking little world." The first stated objective in our bylaws is to assist the Illinois State Medical Society in its program for the advancement of medicine and health education. Our physician husbands live by the principle that the first duty of the medical profession is to render service to humanity. We auxiliary members, in our own way, are trying to match this commitment. Within the frame work of Auxiliary programs we are given the know-how to serve our communities. The National Auxiliary provides a wide range of information and material, the State Auxiliary gives advice, priority suggestions and gentle persuasion. But it is the county Auxiliary that acts.

It is each of you in your county Auxiliary who decides what will be done this year in your town.

One emphasis this year will be on political and legislative activity. IMPAC has drawn up a program to encourage us to be active in political campaigns this fall and to educate us about IMPAC. (Learn how the candidates feel about issues and then work for the candidates who support medicine's beliefs. Plato said, "The punishment of wise men who refuse to take part in the affairs of government is to live under the government of unwise men.") The people we elect this fall are not "merely politicians"—they are our lawmakers.

Now as never before it is important for every doctor's wife in Illinois to stand up for medicine by being an Auxiliary member. Let the public see that you are supporting medicine with your money as well as your voice. Also, we can start right at home to make health an individual responsibility. Each of us decides what foods he eats, what exercise he takes, and whether he avails himself of proper health supervision such as seeking medical care when it is needed and having periodic medical check-ups. This responsibility for one's health cannot be legislated. By actively working at keeping ourselves and our families fit, we will show others we believe proper health habits are important.

In that most important area of knowing, is that of caring for our husbands, Dr. Joseph Trainer of the University of Oregon Medical School makes some interesting remarks in an article for *MD's Wife*. He says we should not let our husband's professional mask fool us. Early in practice he learns to wear a cloak of detachment and independence which can be misinterpreted at home. Be assured our husbands have a need for our attention, approval and affection, he says. It should be a privilege to provide a peaceful, private haven, secure against loneliness and frustration.

As we look backward at our principles and goals they are as timeless as time. Only change is constant. Programs are important but what we are is more important than the programs, i.e. our spirit and purpose. This, in effect, will be a greater force in your work and can bring new heights to the ideas and programs of the auxiliary.

Together we hold the power to be successful, to meet new challenges, to keep strong and to continue to grow.



socio-economic news

By JOSEPH J. LOTHARIUS

Phase II of HASP Ahead of schedule

Phase II of the IFMC sponsored Hospital Admissions & Surveillance Program—HASP—will be functioning in 93 additional hospitals throughout Illinois ahead of the April 15 deadline. The Phase II hospitals are those designated by the Illinois Department of Public Aid as having substantial numbers of Medicaid admissions. Most of these hospitals are within Cook County. Other counties with hospitals in this phase of HASP are Winnebago, Peoria, Rock Island, Lake, Kankakee, Will, Adams, Sangamon, Champaign, Macon, Vermilion, Madison, Jefferson and St. Clair. HASP, which certifies lengths of hospital stays for Medicaid patients, began in seven large Chicago hospitals January 31.

Medicare policy on Nursing home visits

Medicare has clarified its policy on physician reimbursement for visits to nursing home patients (not including patients in extended care facilities). The Bureau of Health Insurance (BHI) said Medicare carriers may process claims for one physician visit per month. Such visits, when medically necessary, require only minimum documentation for approval. When more frequent visits are necessary, detailed documentation should be provided. For a routine visit to one patient in a nursing home, the MD payment is based on the usual and prevailing fee charged for a house call. When a physician sees several patients in a nursing home during the same visit, payment for each patient is based on the usual and prevailing fee charged for an office visit. BHI said the purpose of this policy is to simplify the processing of claims for MD services in non-ECF nursing homes without altering present payment policies for claims in other levels of service.

ISMS refuses to support Drug law changes

The ISMS Board of Trustees refused to support the Illinois Pharmaceutical Association in its efforts to amend the anti-substitution statute of the Illinois Food, Drug & Cosmetic Act. IPhA's proposed amendment would give pharmacists greater latitude in substituting prescribed drugs. IPhA's efforts to change drug labeling laws to permit use of non-proprietary names on prescription labels also failed to get ISMS backing. ISMS Trustees did agree to work with IPhA in developing a Code of Understanding and explore a mutually agreeable procedure for brand selection.

'Medicare misconceptions'
Gets physicians off hook

A new pamphlet from ISMS entitled "Medicare Misconceptions" tells patients why doctors should not be blamed for retroactive claim denials and other problems under the Medicare program. Designed to be inserted in standard billing envelopes, the eight-page pamphlet tells Medicare patients and their families exactly what they should—and should not—expect under Medicare. All ISMS members have been sent a sample copy. The pamphlets are available at \$5 for 500 (less than cost) by writing to: PR Division Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601. Make checks payable to Illinois State Medical Society.



Medicare Misconceptions
Illinois State Medical Society

2

You're now 65 and you've just signed up for Medicare. Well... you'd better know the facts. Medicare is a crutch, not a cure-all. For instance:

- *During 1970 Medicare covered only 43% of health expenditures for those over 65, a slight decrease from 1969. The average person over 65 paid \$225 out of his own pocket for health care, compared to only \$100 for those aged 19-64.
- *Medicare bills once paid without question are now being denied. Whether or not YOUR bill is paid is determined by insurance companies.
- *Many hospital claims paid months or even years ago are being retroactively denied. In Iowa a man was asked to repay the government \$1,621 for a hospital bill paid by Medicare two years earlier.
- *Nursing home benefits are paid ONLY FOR ACUTE CARE NEEDED FOLLOWING HOSPITALIZATION! Simple custodial, or "normal," nursing home care is NOT covered. The physician can only recommend treatment based on medical findings. **THE FINAL DECISION ON HIS CLAIM IS ENTIRELY OUT OF HIS HANDS.**
- Sound grim? Well... too many people assume Medicare covers EVERYTHING! So BEFORE you or a relative file for Medicare benefits, remember that:
- *Medicare reimbursement is not guaranteed... it is not quick... and it is not automatic, no matter what government employees may tell you! Just because your Medicare card is accepted at the hospital office, do NOT assume that your claim will be paid. Remember, physicians and hospitals don't prove claims. Only Medicare insurance carriers determine which bills will—or won't—be paid.
- *Only about one-half of all physicians "accept" Medicare assignments. By "accepting" assignment, the physician must complete paperwork necessary to process a claim. Most doctors believe their job is treating you, the patient... not paperwork!

Hospital Benefits

3

Your hospital insurance won't cover your full hospital bill! Medicare provides you with up to 60 days of hospitalization during each "spell of illness." You pay only \$68 of the entire 60-day hospital bill. If you must stay longer than the 60 days, you pay \$17 for each additional day. If you pay limit. If, after the additional 30 days, still more time is required, you begin to draw on your "lifetime reserve." The "lifetime reserve" is composed of 60 days and you pay \$34 for each day you draw from this reserve.

***DOCTOR BILLS.** They are covered only if you buy supplementary Part B insurance or other private health insurance.

***PRIVATE ROOMS.** Unless your physician certifies it's necessary for "medical reasons."

PAYMENT DENIED FOR REJECTED

Medicare "factsheet"
offered by ISMS

"Medicare Misconceptions," a factsheet which explains to patients what benefits they should—and should not—expect under Medicare, is now available from the ISMS Public Relations Division. Designed to fit in a standard billing envelope, the 3 by 6-inch folder tells why some Medicare claims are denied and that patients SHOULD NOT blame their physicians since only Medicare administrators deny claims.

Rx Product Index

<i>Alpha-Keri</i>	319
Westwood Pharmaceuticals, Inc.	
<i>Dicarbosil</i>	324
Arch Laboratories, Inc.	
<i>Dimetapp/Phenaphen</i>	313-315
A. H. Robins Co.	
<i>Empirin w/Codeine</i>	2nd Cover
Burroughs Wellcome & Co.	
<i>Fleet Enema</i>	245
C. B. Fleet Co., Inc.	
<i>Hydergine</i>	268-269
Sandoz Pharmaceuticals	
<i>Kinesed</i>	262-263
Stuart Pharmaceuticals Division of I.C.I. America, Inc.	
<i>Librium</i>	322-323
Roche Laboratories	
<i>Mylanta</i>	272
Stuart Pharmaceuticals Division of I.C.I. America, Inc.	
<i>Neosporin</i>	267
Burroughs Wellcome & Co.	
<i>Orinase</i>	310-311
The Upjohn Company	
<i>Ornade</i>	3rd Cover
Smith Kline & French	
<i>Pfizerpen VK</i>	270-271
Pfizer Laboratories, Pfizer Inc.	
<i>Premarin</i>	274-275
Ayerst Laboratories Div. American Home Products, Inc.	
<i>Synthroid</i>	254-257
Flint Laboratories Div. Travenol Laboratories, Inc.	
<i>Tepanil/Quinamm</i>	259, 260
Merrell-National Laboratories	
<i>Trobicin</i>	264-265
The Upjohn Company	
<i>V-Cillin K, Pediatrics</i>	276
Eli Lilly & Co.	
<i>Valium</i>	Back Cover
Roche Laboratories	
<i>Vasodilan</i>	250
Mead Johnson & Co.	
<i>Versapen-K</i>	246
Bristol Laboratories	

Skin Saver



Alpha-Keri[®]
therapeutic bath oil
locks in moisture

**relieves dry, itchy skin
with the first bath or shower.**

See PDR. Supplied: 8 and 16 fl. oz. bottles; 5 oz. aerosols.

WESTWOOD PHARMACEUTICALS INC. Buffalo, New York 14213

Send samples of Alpha-Keri bath oil.

DR. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ 7



HOME HEALTH CARE Is Our Specialty

DOCTOR: A MEDICAL EQUIPMENT UNLIMITED Pharmacy can provide the essentials needed to assist your patient in home convalescence or extended care. We deliver all items your patients require to their home on a sales or rental basis.

The following are some of the major items stocked: Convalescent Aids; walkers, wheel chairs, commodes, assist rails, canes, crutches. Orthopedic Equipment; back braces, trusses. Elastic Goods; compression hosiery, (custom fitted and custom made). Incontinent Aids; Exercise equipment, Inhalation equipment, Hospital beds, Colostomy, Osteotomy needs. **WE INVITE YOU** to investigate the services of an MEU Pharmacy by calling one of the following in your area:

CHICAGO

Adams-Woods Pharmacy
5258 West Fullerton
(237-0342)

Broun Pharmacy
2075 Lincoln Avenue
(LI-9-0634)

Bruce & Ken's Pharmacy
7150 West Addison
(685-6300)

Dodge Drug
3235 West 111th Street
(238-6686)

Elsdon Medical Pharmacy
4258 West 55th Street
(LU-2-2660)

Harry Ose Pharmacy
157 West 119th Street
(785-3984)

Lee Lincoln Pharmacy
6193 Lincoln Avenue
(539-1015)

Medical Core Pharmacy
2958 South Wallace
(225-6080)

P. F. Swanson Pharmacy
5259 North Clark Street
(LO-1-3222)

BERWYN

Havranek Pharmacy
6843 West Cermak Rd.
(ST-8-0175)

BROOKFIELD

Lonhort Pharmacy
9046 West 31st St.
(HU-5-2420)

DES PLAINES

Maple Pharmacy
1798 Oakton
(824-6191)

DOWNERS GROVE

Comeo Pharmacy
2752 Maple Avenue
(964-3784)

ELGIN

Munch's Civic Center Pharmacy
101 Douglas
(742-4277)

HOMERWOOD

Niebert Pharmacy
2053 Ridge Road
(799-8552)

MOUNT PROSPECT

Van Driel's Pharmacy
100 East Northwest Highway
(CL-3-6494)

PARK FOREST

Needhams Pharmacy
23450 South Western Avenue
(747-0244)

ROCKFORD

Nowicki Pharmacy
1414 North Main
(815-962-4071)

WESTCHESTER

Nasek Apothecary
1925 Mannheim Road
(865-8900)

WESTMONT

Westmont Pharmacy
2 North Cass
(WO-9-2043)

WINNETKA

Conney Pharmacy
736 Elm Street
(446-3335)

WHEATON

Hawthorne Pharmacy
1425 N. Main Street
(MO-8-7600)

For further information and
locations, Phone (312) 921-5100.
A brochure is available.

the viewbox

(Continued from page 283)

DIAGNOSIS: *Lymphogranuloma Venereum* — roentgen findings are usually limited to the large bowel, especially the rectum. In the acute proctocolitis stage, the rectum and entire colon may be affected but unevenly. The involved areas appear rigid and show a loss of both haustration and mucosal patterns. There may be severe spasm. In the chronic stage anorectal strictures are the commonest radiographic findings. They are most often tubular and are directly continual from the anal area, and of varying length. I have seen involvement up to the level of the splenic flexure in far advanced cases.

The lumen is smoothly reduced and may become string-like. The proximal colon may be dilated in severe cases. Thin horizontal barium projections are frequent and represent short blind sinus tracts; fistulous tracts and perianal abscess can often be demonstrated.

The more severe cases may resemble granulomatous colitis but this disease rarely produces rectal strictures. The rectal involvement and barium spicules projecting from the lumen of many lymphopathia strictures will distinguish the latter from the strictures due to irradiation and other causes.

The condition is far more common in women and is occasionally seen in homosexual men. *Lymphogranuloma Venereum* is a systemic infectious disease caused by a filter passing agent and transmitted by sexual contact.

ekg of the month

(Continued from page 287)

- A) 3,4 Axis is approximately 135° ; axis in adults should be left of 90° . The combination of right axis deviation, normal QRS duration, an R in AVR taller than 5 mm, and a tall R following a small q in V_1 , with inversion of right precordial T waves, is diagnostic of severe right ventricular hypertrophy.
- B) 2,5 The systolic ejection click and loud P_2 suggest significant pulmonary hypertension. The lack of cyanosis and clubbing are against Eisenmengers reaction, and there are none of the usual findings of mitral stenosis. If those potential causes of pulmonary hypertension are eliminated, primary pulmonary hypertension is likely. This is seen more commonly in young women, symptoms occur relatively late, no cause is known so no specific therapy is available, and prognosis is quite poor.

Ulcerative colitis

(Continued from page 282)

criteria for distinguishing the two entities.⁷⁶ The association of ulcerative colitis and primary biliary cirrhosis has been reported;⁸¹⁻⁸² however a case with positive anti-mitochondrial antibodies is lacking.⁸³

Ulcerative colitis has been found in 10-15% of patients with chronic active hepatitis.⁸⁴ Mistilis and co-workers⁷⁴ found eight of 49 patients studied by liver biopsy to have changes consistent with chronic active hepatitis. This represents 2% of their larger series of 441 patients with ulcerative colitis and is in agreement with the figure reported by Edwards and Truelove.²⁹

Ulcerative colitis has been present in approximately 30% of cases of primary sclerosing cholangitis⁸⁵ and was estimated to occur with a frequency of 0.8% in a population of patients with ulcerative colitis. The clinical picture⁸⁶ is identical with that of pericholangitis and an exploratory laparotomy may be required to establish the diagnosis. At laparotomy, difficulty may arise in differentiating this entity from cholangiocarcinoma which also occurs with increased frequency in patients with ulcerative colitis.^{29,86-87} Management is surgical and involves T-tube

drainage or when possible internal decompression of the biliary tract. The disease carries an unfavorable prognosis progressing to cirrhosis and death from liver failure or bleeding esophageal varices in several years.

Differential diagnosis

The therapy of ulcerative colitis, which will be discussed in the final section of this review, must rest upon a firm diagnosis. Diseases apt to be confused with ulcerative colitis or superimposed upon it must be considered. Salmonellosis,⁸⁸ shigellosis and amebic colitis should be routinely excluded through culture and microscopic examination of the stool. Lymphoma of the colon⁸⁹ has been reported as simulating ulcerative colitis. The section which follows, considers two entities which have been delineated recently from ulcerative colitis.

This study was supported in part by the National Institutes of Health Training Grant #05147-14.

Part II of this article will appear in the April issue of the Illinois Medical Journal and deal with "Differential Diagnosis and Treatment."

APPROVED

AVAILABLE NOW!

ISMS

MALPRACTICE INSURANCE

**Professional Liability Insurance
Program**

Approved for Members

**REGARDLESS of AGE
or SPECIALTY**

Protect Doctor's Integrity

Company will settle no claims without insured member's approval. Nuisance claims will be fought.

Improve Legal Climate

Company will retain outstanding defense counsels who are experts in professional-liability cases.

Provide Market Stability

Company will maintain an available market. Participation by the members is needed to assure this market.

Keep Members Informed

Company will tell members how to prevent claims . . . keep them aware of latest legal developments in malpractice field.

ISMS Supervision And Control

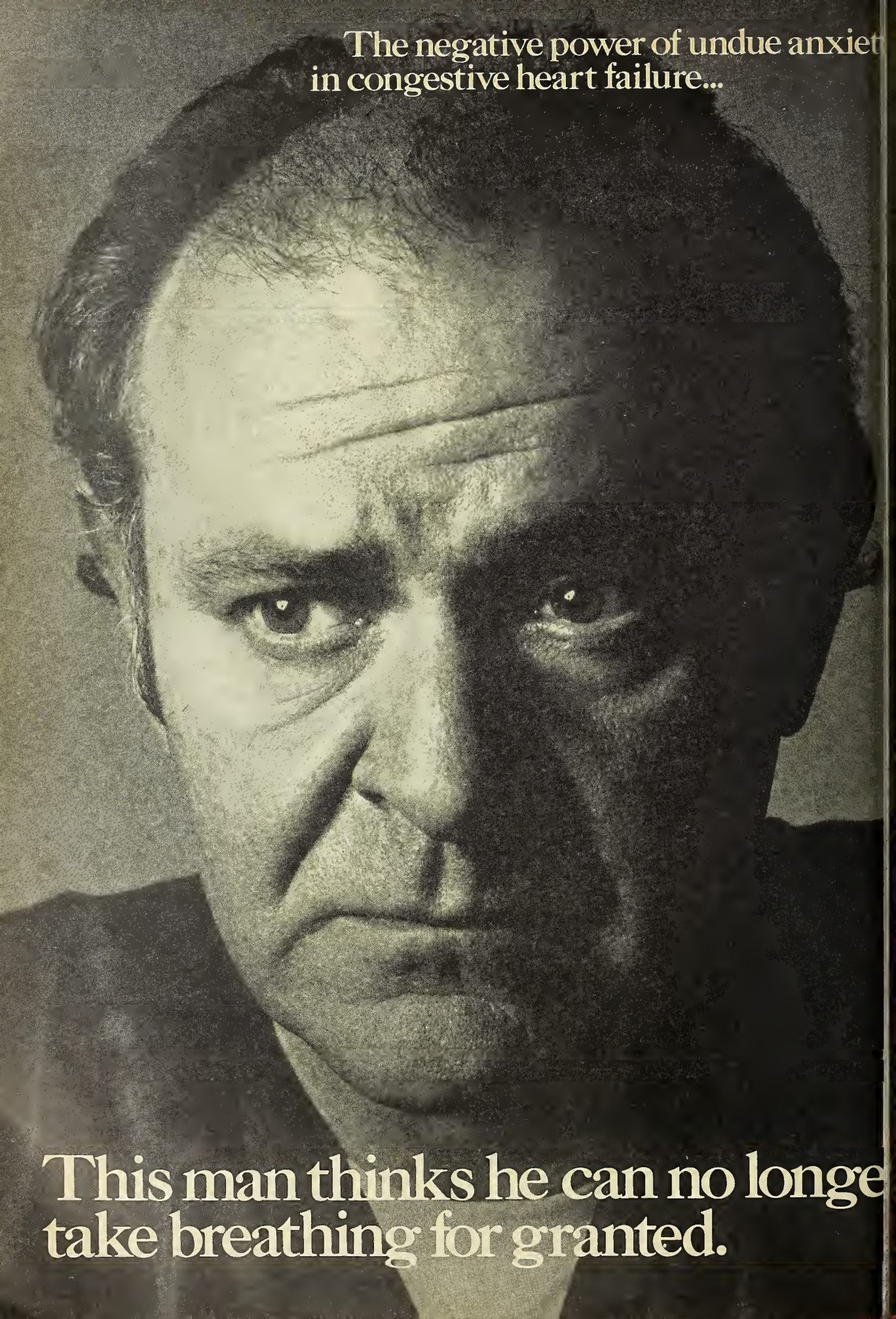
Premiums to reflect only the loss experience of ISMS. All questionable underwriting cases to be reviewed by ISMS. A UNIQUE FEATURE

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT ADMINISTRATORS:

PARKER, ALEXANDER & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

The negative power of undue anxiety
in congestive heart failure...



This man thinks he can no longer
take breathing for granted.

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

Aid in rehabilitation

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents
Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

The positive power of

Libritabs®

(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

t.i.d./q.i.d.

up to 100 mg daily

for severe anxiety accompanying congestive heart failure

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

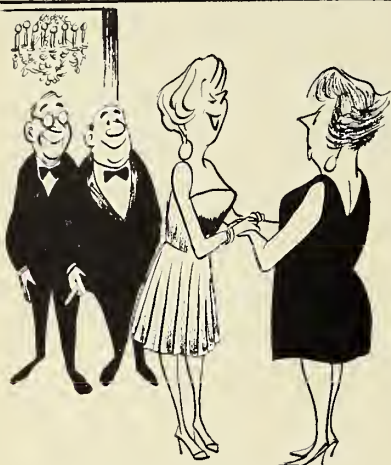
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



*"Your dinner was
perfect—from soup
to 'Dicarbosil'."*

Dicarbosil®

ANTACID



Write for Clinical Samples

ARCH LABORATORIES

319 South Fourth Street, St. Louis, Missouri 63102

COOK COUNTY Graduate School of Medicine

CONTINUING EDUCATION COURSES
STARTING DATES—1972

SPECIALTY REVIEW COURSE IN NEUROLOGY, Basic, April 3
SPECIALTY REVIEW COURSE IN PEDIATRICS, April 17
REVIEW COURSE IN NEUROPATHOLOGY, April 10
SPECIALTY REVIEW COURSE IN THORACIC SURGERY, April 17
SPECIALTY REVIEW COURSE IN DERMATOLOGY, May 8
SPECIALTY REVIEW COURSE IN OB-GYN, May 8
SPECIALTY REVIEW COURSE IN MEDICINE, May 22, June 5
STATE & NATIONAL BOARD REVIEW, Basic, April 9
STATE & NATIONAL BOARD REVIEW, Clinical, April 17
SURGERY OF THE GASTROINTESTINAL TRACT, One Week, April 10
FUNCTIONAL & ANATOMIC DISTURBANCES OF ESOPHAGUS, April 6
BLOOD VESSEL SURGERY, One Week, May 1
ADVANCES IN SURGERY, One Week, May 8
SURGERY OF TRAUMA, Four Days, May 15
BASIC GYNECOLOGY, One Week, April 10
BASIC OBSTETRICS, One Week, April 24
ADVANCES IN MEDICINE, One Week, May 8
FAMILY PRACTICE REVIEW, One Week, May 8
BASIC DERMATOLOGY, One Week, May 1

*Information concerning numerous other continuation
courses available upon request.*

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

Ectopic pregnancy

(Continued from page 286)

Dr. Beal: Dr. Poticha, the patient had a differential diagnosis of acute appendicitis, pelvic inflammatory disease, and ectopic pregnancy. I am curious as to why the X-rays of the abdomen were ordered. Are they really necessary?

Dr. Poticha: X-rays of the abdomen would not be of help in differentiating between these three diseases and were probably not indicated in this case. In most cases of appendicitis, radiographic examination of the abdomen is not necessary, although a chest X-ray should be obtained before surgical exploration. On the other hand, diseases such as perforated peptic ulcer or right ureteral calculus occasionally present with right lower quadrant pain. When these diseases are seriously considered in the differential diagnosis, X-rays of the abdomen may be helpful.

Dr. Beal: I was interested in the history of ectopic pregnancy. There is a little book, published a number of years ago by Zachary Cope, *PIONEERS IN ACUTE ABDOMINAL SURGERY* (Oxford University Press, London, 1939). Ectopic pregnancy was a baffling, uniformly lethal problem until the latter part of the nineteenth century. The first definitive treatise on the subject was by J. S. Parry of Philadelphia, who wrote in 1876 that successful treatment of ectopic pregnancy would require operation. It was in 1881, in Birmingham, England, that a physician, Mr. Hallwright, had a patient in whom he made the diagnosis of ectopic pregnancy. He urged a famous gynecologist, Lawson Tait, to operate upon this patient. However, Tait couldn't bring himself to intercede, and then to his chagrin found that the patient did indeed have an ectopic pregnancy when she died. Two years later, however, under similar circumstances, Tait operated first unsuccessfully, and then in 1884, did accomplish the first successful removal of an ectopic pregnancy.

*You're invited . . .
to a
Washington Roundup
April 16-18*

See page 253

★
Specialized Service
 IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

**THE
 MEDICAL PROTECTIVE COMPANY**
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO AREA OFFICE: T. J. Pandak, J. C. Kunches, and L. R. Gannon, Representatives
 T. J. Hoehn, Consultant
 815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
 SPRINGFIELD OFFICE: W. J. Nattermann, Representative
 426½ South Fifth Street, Springfield 62701 (217) 544-2251

ANOTHER **ISMS** MEMBERSHIP PRIVILEGE LOW-COST GROUP INSURANCE

GROUP DISABILITY PLAN

- NEW—Guaranteed renewable feature
- Sickness benefits to age 65
- Up to \$250.00 weekly benefits

(PROTECT YOUR INCOME AND SECURITY)

GROUP SUPER MAJOR MEDICAL PLAN

- Up to \$50.00 daily room and board
- Up to \$25,000 for each accident or sickness
- In hospital and out of hospital expenses

(TRULY CATASTROPHIC PROTECTION)

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, MESSIAH & COMPANY
 ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
 Skokie, Illinois 60076
 Phone: 312-679-1000

what goes on

a guide to continuing education

March 31-April 1—University of Wisconsin

Seventh Annual Teaching Days in Sports Medicine

Presentation of research papers dealing with marathon running, function of the heart after surgery, and functions of the lung in health, and disease at sea level and altitudes. Also panel discussions on the role of the high school trainer, resuscitation on the field, and use and abuse of things in sports.

Contact: Dept. of Postgraduate Medicine, 610 N. Walnut St., Madison, Wis. 53706.

Wisconsin Center, 702 Langdon St., Madison, Wis.

April 6-8—Council on Medical Service of the AMA

Sixth National Congress on the Socio-Economics of Health Care

"Health Services in the '70's" will be developed in a series of three in-depth explorations which include the mix of health care financing, the structure of health care delivery, and the challenge to improved services.

Pre-registration and additional information may be obtained by contacting the AMA, 535 N. Dearborn, Chicago, Ill. 60610.

Fort Lauderdale, Fla.

April 7-14—International Academy of Proctology

24th Annual Congress and Teaching Seminar of the International Academy of Proctology

Contact: International Academy of Proctology, 147-41 Sanford Avenue, Flushing, New York 11355, Attn: Alfred J. Cantor, M.D., Registration fee is \$50.

Town and Country Hotel, San Diego, Calif.

April 10-12—American Cancer Society

14th Western Cancer Seminar

For additional information and pre-registration contact: Cancer Seminar, American Cancer Society, 301 S. Highland Dr., Las Vegas, Nevada 89106.

Registration fee for physicians is \$25.

Flamingo Hotel, Las Vegas, Ne.

April 14-15—Mayo Clinic

Second F. R. Keating, Jr. Symposium

"Graves' Disease 1972" is the topic to be discussed.

Contact: A. B. Hayles, M.D., Mayo Clinic, Rochester, Minn. 55901. Registration fee is \$65, and \$10 for residents.

Mann Hall, Mayo Clinic, Rochester, Minn.

April 15—Taylor Manor Hospital

4th Annual Taylor Manor Hospital Psychiatric Symposium

"Man and His Moods"—the biochemical and physiological bases for normal and abnormal moods and the clinical manifestations of mood changes will be explored by such experts at Nobel Laureate, Dr. Julius Axelrod, National Institute of Health; and Gerald Klerman, M.D., professor of psychiatry, Harvard Medical School.

Ellicott City, Me.

April 16-22—University of Kentucky

Annual Family Medicine Review

The fee is \$175.

University of Kentucky Medical Center, Lexington, Ky.

April 17-19—Great Lakes Health Contest

Health Care—A Community Affair

General assemblies, seminars, multi-disciplinary sessions and departmental educational confabs on: anesthesia, medical records, food management, public relations, etc.

Contact Alfred Van Horn III, Great Lakes Health Congress, 400 N. Michigan Ave., Chicago 60611 or (312) 321-0317.

McCormick Place-on-the-Lake, Chicago

April 24-27—American Academy of Pediatrics

Annual Spring Session

Current concepts in pediatric cardiology, what the pediatrician should know about systemic hypertension in childhood, problems of the adolescent, pediatric emergencies, and respiratory distress syndrome are among the subjects to be presented.

San Diego, Calif.

April 24-27—American College of Surgeons Committee on Trauma and Johnson and Johnson Company

Treatment of the Seriously Injured or Ill in the Emergency Room

Trauma, acute medical problems, psychiatric problems and pediatric problems will be discussed. Registration will vary between \$50-75 for the first of the proposed 13 courses to be presented across the nation. Each course is approved for credit by the AMA toward its Physician's Recognition Award.

(See "What goes on" in the coming months for the dates and sites of other courses on this subject.)

Contact: Trauma Division, American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611.

St. Louis, Mo.

April 26-27—The Cornell Medical Center

International Symposium on Analgesics

No registration fee.

1300 York Avenue at East 69th Street, New York, N.Y.

April 27—University of Louisville School of Medicine and Kentucky Chapter, Arthritis Foundation

Eighth Symposium on Rheumatic Diseases

For additional information contact: Symposium Program Committee, Kentucky Arthritis Foundation, 1381 Bardstown Rd., Louisville, Ky. 40204.

Louisville, Ky.

April 27-28—American Association of Railway Surgeons

Spring Meeting

Topics include: Contact Lens in Industry; Burns; Hip Replacement; and Hypertension.

Drake Hotel, Chicago

May 10-13—Chicago Committee on Trauma of the American College of Surgeons

Postgraduate Course on Fractures and Other Trauma

The program is intended for all who care for injured patients and is acceptable for 28 elective hours by the American Academy of Family Practice.

Registration and additional information can be obtained by contacting: American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611. Registration fee is \$125 for physicians, and \$30 for interns, residents and allied health personnel. Chairman's reception and three luncheons are covered in this fee

Sheraton-Chicago Hotel, Chicago, Ill.

Medical menopause

For nearly 20 years as a medical management consultant I have been watching physicians venture unwarned into medical menopause, and a few years later come stumbling out dazed and uncertain as to why their personal life is in so grave a disorder just when they've got their professional life straightened out.

A wife who was tolerant and supportive of professional drive will not respond graciously when her husband attacks golf with the same passion he devoted to orthopedics. If the doctor's spouse begins to suspect that her husband's growing activities are inspired by motives considerably more libidinous than intellectual, the spark of hellfire has been kindled.

Whatever the outlet for the doctor, it seldom involves his mate to any greater extent than for the last 10 years. Therein sprout the seeds of disaster.

A doctor in his prime years gets more chances to play than other people. Schedules are more flexible than most. Financial resources exist for travel, club memberships, for boats, airplanes, even for a mistress, or at least less formal liaisons. My theory is that the menopausal medico now learns how to play, but seldom learns how to relax. (Gardiner Apperson.: "A Time of Peril: 'Having It Made,'" *Medical Opinion*, Jan., 1972, pp. 30-33.)

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

IMMEDIATE OPENING: Obstetrician-Gynecologist, Board certified or eligible, to join 5-man department of busy multispecialty clinic. Member-owned, located in university community with opportunity for teaching or research. Liberal fringe benefits, excellent salary initially leading to full association. Send cv to Medical Director, Carle Clinic, Urbana, Illinois 61801.

INTERNIST with subspecialty in pulmonary and chest diseases urgently needed in busy, expanding multispecialty clinic. Good development potential. Liberal benefits and salary leading to full association. Located in university community with opportunity for teaching or research. Contact Medical Director, Carle Clinic, Urbana, Illinois 61801.

REGIONAL MEDICAL DIRECTOR WANTED: Board certified or eligible in Internal Medicine or Occupational Medicine. Largely administrative with some clinical responsibilities; NW suburb of Chicago; some travel necessary. Contact Union Oil Co. of California, 200 E. Golf Rd., Palatine, Illinois 60067 or call (312) 529-7676 Ext. 227.

WANTED NOW: GENERAL SURGEON to practice with 10 man group in Hibbing, Minnesota. Great area for one interested in hunting, fishing, snowmobiling, skiing, or any out of door living. Superior schools, junior college. Modern clinic building but two blocks from excellent hospital facilities. Patient area of 50,000. Compatible staff. Call collect or write to: John J. Muller, M.D. or O. A. Seavey, Administrator, Adams Clinic, P. A., Hibbing, Minnesota 55746—Telephone: (218) 262-3425.

FAMILY PRACTICE: small town, large practice in beautiful Kettle Moraine of Wisconsin. City hospital and advantages nearby, four day week in association with experienced AAFP Physician. Write to P. O. Box 797, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. \$30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

WANTED ANESTHESIOLOGIST: Board Certified or Eligible. Outstanding opportunity to join group of two (2) Anesthesiologists and ten (10) nurse anesthetists operating in expanding 700-bed private hospital, affiliated with new Medical School. This position would be salaried with partnership to follow; fringe benefits and unusually good prospects. Location: Central Illinois. Write to Box Number 794, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

FAMILY PRACTITIONERS, Fairfield, Illinois 6000 population—Excellent schools and recreational facilities for your family. Write or call collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837—Telep. (618) 842-2167.

IMMEDIATE OPENING: INTERNIST or GENERAL PRACTITIONER to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practicing physicians (General Practitioners) in the community outside of our Clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd. Two Rivers, Wisconsin 54241.

WANTED ASSOCIATE IN GENERAL PRACTICE. Join 2 men in established incorporated practice in large northern suburb of Chicago. Excellent schools and cultural advantages. Dealing primarily in internal medicine. No OB or Surgery. Practicing in 500-bed teaching hospital. Contact Bernard Berne, M.D., 603 Main Street, Evanston, Illinois 60202.

GENERAL PRACTITIONER—Full or Part time. Industrial medical center, located in Niles, Morton Grove, Skokie Industrial area. No Sundays, No nights, No Holidays. Phone: (312) 647-0355.

INTERNIST or GENERAL PRACTITIONER wanted for Illinois community of 5,000 population on Mississippi River 40-bed open staff hospital. Exceptional recreational facilities. Excellent schools. Churches of all denominations. Option to practice alone or in partnership. Guaranteed salary. Send reply to: William J. Dayton, 202 Meadowview Knoll, Savanna, Illinois 61074.

FOURTH EMERGENCY ROOM PHYSICIAN—Illinois licensed—for 300-bed hospital—new ER—rotates 24 hours every fourth day—light p.m. duty—in mid-downstate suburbia. Area serves 125,000. Excellent salary and fringes. Send letter and curriculum vitae to P.O. Box 798, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

IMMEDIATE OPENING for OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

OUTPATIENT SERVICE STAFF PHYSICIAN with primary responsibility for examination of applicants to determine medical eligibility for hospitalization and other VA benefits. 216-bed modern general hospital with active medical and surgical services. Salary dependent upon qualifications. Excellent fringe benefits. Can pay moving expenses. License any state required. Equal Opportunity Employer. Contact Hospital Director, Veterans Administration Hospital, Fort Wayne, Indiana 46805, or call (219) 743-5431, Extension 310.

MEDICAL SERVICE STAFF PHYSICIAN—Board certification in Internal Medicine preferred. 216-bed modern general hospital with active medical and surgical services. Salary dependent upon qualifications. Excellent fringe benefits. Can pay moving expenses. License any state required. Equal Opportunity Employer. Contact Hospital Director, Veterans Administration Hospital, Fort Wayne, Indiana 46805, or call (219) 743-5431, Extension 310.

PSYCHIATRIST—Group therapy and individual student practice with some administrative duties. Salary per qualifications, fringe benefits; some private practice possible. Convenient to metropolitan Chicago. Minimal qualifications: Residency completed and Illinois license. Phone or write: Loren W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, Illinois 60115. (815) 753-1311.

GYNCOLOGIST full-time for Gyn Clinic in large well-developed university health service in modern facility. Fringe benefits including one month's annual vacation, retirement benefits, hospitalization insurance. Must qualify for Illinois license. Contact Loren W. Akers, M.D., Director UHS, Northern Illinois University, DeKalb, Illinois 60115.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

Blue Shield Offers Three New Indemnity Programs

The Blue Shield Plan of Illinois Medical Service has developed three new indemnity programs to be offered on a group basis. The programs, identified as Series R600, Series S800 and Series T1000, went into effect April 1, 1972.

These new programs now allow Blue Shield to pay a greater allowance on an indemnity basis. Groups will now be offered an indemnity certificate with a \$600, \$800, or \$1000 surgical schedule.

A Blue Shield indemnity certificate is one which allows specific dollar payments to be made for covered services. The amounts of indemnity are enumerated and are not intended to fix the charge of the physician's services or to relate to such charge. Physicians charge their usual fees for services. The patient is responsible for any difference between the physician's fee and the amount specified in the schedule of indemnities.

The dollar limit on the indemnity certificate is the maximum allowance scheduled for a surgical procedure. This means that allowance schedules are set so that the maximum which would be paid for the most complex type of surgical procedure would be \$600, \$800, or \$1000, depending on which of these new programs applies.

The three new indemnity programs have a broad scope of benefits. Under these certificates, Blue Shield members are protected, in part, against the cost of a technical surgical assistant when such technical surgical assistance is certified as medically necessary and interns, residents or house staff are not available. Payment can be made for up to 20% of the amount specified in the indemnity schedule for the procedure performed.

Payment is also available for a consultation. Payment, not to exceed a scheduled allowance, can be made to another physician when the treatment of the subscriber requires and the attending physician requests a consultation. Payment is limited to one consultation per admission in a hospital or extended care facility and will not be made to a physician who has previously received payment for service under the surgical or obstetrical provisions of these certificates or for radiological or pathological consultations.

The scope of benefits of the R600, S800 and T1000 indemnity programs also includes specified payments for surgery, wherever performed, anesthesia, obstetrical care, in-hospital medical care, radiation therapy, emergency accident care, emergency medical care, coordinated home care, and in-hospital radiological and pathological examinations when consistent with the diagnosis.

Blue Shield has offered indemnity programs for over 25 years. The Series R600, S800, and T1000 are three more choices Blue Shield provides to groups for meeting their health care costs.

National Account Blue Shield Claims Processed By Illinois Medical Service

Illinois Medical Service now processes Blue Shield claims for twelve national groups. Illinois physicians who treat a patient having a Blue Shield membership under any of the certificate numbers listed below can receive payment for their services by completing a Physician's Service Report in the usual manner and sending it to the Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601 rather than to the out-of-state Plan. Please be sure to include the complete identification number (letter prefix plus social security number) when filing for benefits.

AHS-121	American Hospital Supply
ATT-303 (90338)	American Telephone and Telegraph
KAG-101	Kaiser Agricultural Chemicals
KAG-601	
SHW-333	Sherwin Williams Company
AV-303	Avis Rent-A-Car
WER-303	Western Electric Retirees
LAB-303	Bell Laboratories Retirees
TTY-303	Teletype Retirees
MJR-303	Manufacturer Junction Railway Retirees
KIN-303	Kinney Services
HAS-303	Haskins & Sells

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Durable Medical Equipment Coverage Under Medicare

Items of durable medical equipment which a physician orders for a patient who is covered by Medicare for use in that patient's home may be eligible for coverage under Part B Medicare. Medicare payments can be made to a beneficiary or to a supplier for the rental or purchase of such an item if:

1. it meets the definition of durable medical equipment,
2. it is reasonable and necessary for the treatment of a patient's illness or injury or to improve body function, and
3. it is used in the patient's home.

Durable medical equipment is defined by the Social Security Administration to be equipment which:

- a. can withstand repeated use, *and*
- b. is primarily and customarily used to serve a medical purpose, *and*
- c. generally is not useful in the absence of an illness or injury.

Equipment, such as air conditioners, humidifiers, or other items used for environment control, which is primarily and customarily used for a nonmedical purpose is *not* considered durable medical equipment by the Social Security Administration.

Nor does the Social Security Administration consider equipment which basically is used for comfort or convenience purposes to be medical equipment. Also, physical fitness equipment, self-help equipment, first aid or precautionary equipment, training equipment, hygienic equipment, equipment used in preventive care, and cosmetic equipment are *not* considered medical equipment.

However, in the case of hygienic equipment, equipment used in preventive care, and cosmetic equipment, payments may be allowed if these items serve a therapeutic purpose. Items such as bed bath equipment for a bed patient for use in treatment of his condition, gel pads or water mattresses for a patient who has or is susceptible to decubitus ulcers, or heat lamps where the need for heat therapy has been established would fall into this category. It must be demonstrated, however, that the item is included in the physician's course of treatment and a physician is supervising its use.

Some examples of generally acceptable items of durable medical equipment are wheelchairs, canes, crutches, hospital beds, suction machines, and hemodialysis equipment. Water purification systems for use in conjunction with a home hemodialysis machine which is approved for coverage under

Part B Medicare would be covered where there is a need to purify the water supply to remove heavy trace metals and/or organic substances.

For durable medical equipment coverage, a patient's home may be the patient's own dwelling, an apartment, a relative's home, a home for the aged or some other type of residential institution. However, an institution would not be considered a patient's home if it meets a) the basic requirements in the definition of a hospital or b) at least the basic requirements in the definition of an extended care facility.

The Medicare program also allows payments for repair, maintenance, and replacement of medically required durable medical equipment which the patient *owns or is purchasing*. Replacement is covered for loss or irreparable damage or wear or when required because of a change in the patient's condition. A physician's order is necessary when replacement is made because of wear or a change in the patient's condition.

Supplies, such as oxygen, and accessories, such as tubes, hoses and mouthpieces, are covered when they are essential to the effective use of the equipment. No payment can be made for medications used with the equipment since these fall within the Part B Medicare drug restrictions.

The Medicare patient determines whether the equipment is to be rented or purchased. Either the patient or the supplier applies for payment by completing an SSA 1490, Request for Medicare Payment form. The physician should furnish the patient or the supplier with an order for the equipment and must indicate the diagnosis, the use for the equipment and the anticipated length of time the patient will require the equipment.

Physicians with questions regarding the durable medical equipment they order for a patient covered by Medicare should contact their Professional Relations Representative or the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601.

SSA Changes In Lab Certification

The following laboratory has withdrawn from participation in the Medicare program as of April 1, 1972. No payment will be made under Medicare for services provided by the laboratory on or after that date.

Arms Medical Laboratory
414 South Oak Park Avenue
Oak Park, Illinois 60302

(This is not an advertisement)



illinois medical journal

volume 141, number 4

April, 1972

staff	editor	Theodore R. Van Dellen, M.D.
	managing editor	Richard A. Ott
	assistant editor	Michaelyn Sloan
	advertising manager	John A. Kinney
	executive administrator	Roger N. White

clinical articles	Ulcerative colitis—Selected clinical, diagnostic and therapeutic aspects (Second part) <i>James L. Franklin, M.D., and Joseph B. Kirsner, M.D.</i>	355
	Measles in previously vaccinated children in Illinois <i>Philip J. Landrigan, M.D.</i>	367
	Management of abdominal trauma in children <i>John G. Raffensperger, M.D.</i>	373
	Maternal death study case report No. 2 <i>Robert E. Hartman, M.D.</i>	379
	Retroperitoneal and gluteal cystic lymphangioma <i>Miguel A. Oviedo, M.D., Norman E. Larson, M.D., F.A.C.S. and Gerald Parent, M.D.</i>	381
	Prenatal hormones and human behavior <i>Anke A. Ehrhardt, Ph.D., and John Money, M.D.</i>	386
	Car restraint devices designed for children <i>Eugene F. Diamond, M.D., and Frederick Burg, M.D.</i>	390
surgical grand rounds	Pancreatic transplantation	362
features	the presidents page	344
	the viewbox	361
	ekg of the month	366
	editorials	392
	membership forum	393
	practice management	400
	clinics for handicapped children	402
	obituaries	409
	socio-economic news	412
	doctors library	414
	pulse of the doctor's wife	416
	what goes on	418

(Cover art by George Brownlee)

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601. Copyright, 1972, The Illinois State Medical Society.

Subscription \$5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$7.50 per year for all foreign countries included in the Universal Postal Union. Canada \$5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.



REGISTERED
AIA
MEDIA DATA FORM

PREMARIN[®]

(CONJUGATED ESTROGENS TABLETS, U.S.P.)

**HELPS RELIEVE EMOTIONAL
SYMPTOMS OF MENOPAUSAL
ESTROGEN DEFICIENCY**

**BECAUSE
IT GIVES HER BACK
SOMETHING SHE'S LOST**



Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

Aid in rehabilitation

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

The positive power of

Libritabs®
(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

t.i.d./q.i.d.

up to 100 mg daily

for severe anxiety
accompanying
congestive heart failure

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

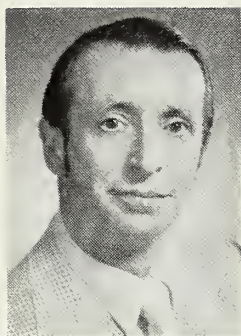
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



the presidents page

What "health care crisis"?

CERTAIN POLITICAL OPPORTUNISTS in Washington are trying to knock out American medicine with a fancy phrase called the health care crisis.

The so-called health care crisis is . . . in fact . . . mostly a myth manufactured by political cinderellas who hope to turn it into a coach that rolls straight into the White House. But let's take a close look at what the health care experts on the Potomac call the health care crisis.

They say there is a crisis because there are not enough doctors, what doctors there are aren't located in the right places, and that we want it that way for our own selfish ends.

They say there is a crisis because there is not enough health care available in the ghetto and small town.

They say there is a crisis because health care costs have soared so high that health care is not accessible to major segments of the population.

In a nutshell . . . gentlemen . . . they're saying that there are too few doctors providing too little care and what there is costs too much money and isn't being spread around enough. We're not dispensing medicine anymore . . . apparently we're dispensing the high-priced spread!

Well . . . no one knows better than we do that there's a doctor shortage. When we roll into bed at midnight or 1 a.m. and roll out again at 6 a.m. . . . when we drive to the hospital every Sunday morning . . . the doctor shortage is very clear indeed.

Of course we do it for the money . . . gentlemen. We LIKE to work a 65 hour week! We really don't MISS our wives and children!

We LIKE the sixteen hour day, the seven day week. We LIKE to treat more patients and make more money that we don't get a chance to spend.

Yes . . . we like all these things. That's why America's physicians since 1962 have given medical schools \$50 million to help enlarge medical training facilities.

That's why in the last nine years the American Medical Association has guaranteed \$48 million worth of loans to medical students. At this very minute more than 7,500 students are either in school or intern-residency training with AMA-guaranteed loans.

That's why right here in Illinois we strongly supported the establishment of U of I medical school branch campuses at Rockford, at Peoria, at Champaign.

That's why we supported legislation to secure a \$6.5 million loan for Chicago Medical School to expand its facilities . . . the first such grant ever given to a private institution.

That's why since 1960, while the number of physicians has increased by 28 percent, the population increased only 12 percent.

And what about the lack of health care in the ghetto and small town? What about the maldistribution of doctors in Illinois?

It's true . . . you know . . . doctors too are moving to other communities. But it's no secret that druggists, plumbers and corner grocers are moving to the suburbs too.

What about care costs?

And what about the costs of health care? We did increase our fees an average of 8.5 percent during 1970 you know. Never mind that plumbers and plasterers received 13 percent wage increases, and carpenters, bricklayers and electricians 11 percent increases.

(Continued on page 403)



BY JAMES L. FRANKLIN, M.D., AND JOSEPH B. KIRSNER, M.D., PH.D./CHICAGO

Ulcerative colitis

Selected clinical, diagnostic and therapeutic aspects

Second part

THE FIRST PART of this article, presented in the March *IMJ* dealt with the clinical aspects of ulcerative colitis and covered the areas of epidemiology, local complications such as toxic megacolon and carcinoma, systemic manifestations i.e. arthritis, ulcerative colitis in childhood and disease of the liver. The second and concluding section of this article covers the differentiation between ulcerative colitis, granulomatous colitis and ischemic colitis, and current concepts in the treatment of inflammatory bowel disease.

Differential diagnosis and treatment Chronic Ulcerative Colitis versus Crohn's Colitis

Wells⁹⁰ and Brooke⁹¹ are credited with recognizing that certain cases previously considered to be ulcerative colitis had features which pathologically more closely resembled regional enteritis (Crohn's disease). As Zetzel⁹² pointed out, historically this was one of the "few occasions with an eponym, Crohn's disease of the colon, suggested by the English, was for a long time rejected by the person so honored." The last decade has seen the full definition of this entity

evolve⁹³⁻¹⁰⁰ and there is now recognition of the fact that many of the diagnostic criteria hitherto felt to be the absolute rule have significant exceptions.¹⁰¹⁻¹⁰²

Clinically, age and sex ratios in these two conditions are not so dissimilar as to be of diagnostic significance. A history of rectal bleeding is characteristic of ulcerative colitis, yet may be a complaint in up to one-third of patients with granulomatous colitis.¹⁰⁰ While diarrhea is common to both diseases, in Crohn's colitis it is a true diarrhea while in ulcerative colitis, it is frequently merely the passage of blood and mu-

Ulcerative Colitis

cous. Perianal disease, fissures, fistulae and abscesses, highly characteristic of Crohn's colitis occurring in approximately 80% of cases, remains relatively rare in ulcerative colitis. Anal disease may in granulomatous colitis be the first manifestation of disease¹⁰³ in 25% of cases.

Sigmoidoscopy reveals rectal involvement in over 90% of patients with ulcerative colitis while in granulomatous colitis rectal involvement is seen in only 25% of patients. The proctoscopic picture in ulcerative colitis is that of narrowing, uniform granularity, friability and blood stained mucous; while in Crohn's colitis, the prominent feature is edema with scattered irregular ulcers. The granularity of the former condition is lacking and patches of normal mucosa may be seen between involved areas of granulomatous colitis. The value of rectal biopsy in patients with Crohn's colitis has been somewhat debated. McGovern and Goulston⁹⁹ found no diagnostic features in eight biopsies. Dyer et.al.¹⁰⁴ reported their results with rectal biopsy in Crohn's disease, finding diagnostic abnormalities in 23% of their 79 patients. Only in those patients where colonic involvement was distal to the splenic flexure was the biopsy diagnostic and in only two of 39 biopsies from sigmoidoscopically normal mucosa was a diagnostic abnormality found. We do not routinely perform rectal biopsies in evaluating patients who have a normal mucosa as seen with an unprepared proctosigmoidoscopic exam.

Radiologic findings in Crohn's disease differ from ulcerative colitis in their segmental distribution, predominance of right-sided involvement, sparing of the rectum, asymmetry of the lumen, the presence of fistulas, sinus tracts, and transverse and longitudinal fissures. In ulcerative colitis, the rectum usually is narrowed with an increase in the rectosacral distance. In ulcerative colitis two types of ulcers are recognized: either small serrations or large "collar-stud" undermining ulcers. In Crohn's disease the ulceration presents as deep longitudinal and transverse fissures penetrating through the mucosa and resulting in a "cobblestone" appearance.

The macroscopic features of surgical specimens which distinguish ulcerative colitis from granulomatous colitis include continuity of mucosal involvement versus sparing of the rectum and segmental involvement, granularity and shallow ulceration as opposed to the deep linear

ulcerations and the cobblestone appearance of the mucosa in Crohn's disease. Schachter and co-authors¹⁰² recently reported analysis of the histologic features in 100 consecutive proctocolectomy specimens. They emphasized that in addition to the clinical and radiologic features known to overlap in ulcerative colitis and granulomatous colitis, individual histologic characteristics might be present in both entities making pathologic differentiation also difficult. This was found to be true for granulomas which were noted in 14 of 18 histologically diagnosed cases of Crohn's colitis but were also found in 2 of 79 cases histologically felt to be ulcerative colitis. Lymphangiectasia also was found in both entities and difficulty was encountered distinguishing fissures from undermining ulcerations. The non-specific nature of crypt abscesses was reaffirmed.

Carcinoma in association with ulcerative colitis is more common than with granulomatous colitis, but carcinoma is being reported in association with Crohn's colitis.¹⁰⁵ Morson¹⁰⁰ comments that he has not seen pre-cancerous changes in the mucosa of specimens with features of Crohn's colitis. Toxic dilatation of the colon in patients with Crohn's colitis²⁴ also is well recognized. A recent report¹⁰⁶ describes the incidence of toxic megacolon in granulomatous colitis to be as high as 16%, a figure approaching the 20% mark for ulcerative colitis.

Until the etiology and pathogenesis of these two conditions are understood, an attempt to define and classify these syndromes is necessary. The frequency of ileostomy revision following colectomy in histologically proven Crohn's colitis¹⁰⁷ was greater than ulcerative colitis, but the overall clinical course in the two conditions was similar. The frequent recurrence and progression of disease associated with resection in regional enteritis was not observed following colectomy. This view is supported by others.¹⁰⁸

A patient recently seen at the University of Chicago Clinics illustrates the need for long term follow-up studies on the question of prognosis following total colectomy for Crohn's colitis versus ulcerative colitis.

A.H., a 19-year-old man, was first seen at age nine (1962) for an illness diagnosed as right-sided colitis. After two years of recurrent illness and abscess formation he underwent a total proctocolectomy and ileostomy. The patient enjoyed seven years of good health with normal growth

and development, but then developed fever, weight loss and malaise with vague abdominal discomfort. A small bowel study revealed changes typical of Crohn's disease. (Re-evaluation of the histology of the colon revealed deep transmural fissures and innumerable granulomas with Langhan's giant cells.)

There have been several studies evaluating laboratory methods for distinguishing ulcerative colitis from Crohn's colitis. A pronounced decrease in epithelial mucosal mucin has been found in patients with ulcerative colitis while their mucosubstances are preserved in patients with granulomatous colitis.^{100,109} Similarly, the *in vitro* inhibition of peripheral leukocyte migration by components of colonic mucosa has been reported¹¹⁰ in ulcerative colitis but not in granulomatous colitis. The value of these studies remains uncertain and currently the clinician must rely upon the history, proctoscopic findings, supplemented by rectal biopsy, and finally radiologic studies of large and small intestine to determine if his patient has ulcerative colitis or granulomatous colitis. There will remain a group of approximately 10% not readily classified.

Ulcerative Colitis versus Ischemic Colitis

As indicated in the discussion of epidemiologic features of ulcerative colitis, there is a rise in the incidence of ulcerative colitis in the elderly, associated with a poor prognosis. Recent experience suggests that at least some of these cases were instances of ischemic colitis. While earlier descriptions of ischemic colitis exist,¹¹¹ Marston and co-workers¹¹² should be credited with having delineated and classified this syndrome. They recognized three groups of patients: (1) ischemic colitis with gangrene requiring immediate surgery; (2) ischemic stricture formation in the region of the splenic flexure with abdominal pain, rectal bleeding and requiring local resection; and (3) transient ischemic colitis presenting with abdominal pain, rectal bleeding and characteristic thumbprinting seen on barium enema. This last group responded to expectant therapy. Their observations and subsequent studies,¹¹³⁻¹¹⁴ stress the finding of a normal appearing rectal mucosa with bleeding seen to come from above in arriving at a diagnosis of ischemic colitis.

Two syndromes,¹¹⁵⁻¹¹⁷ an early and late form of colonic ischemia, have been observed following the resection of abdominal aortic aneurysms. This complication is related to the need to sacrifice the inferior mesenteric artery in this procedure. In both forms of this syndrome, definite proctoscopic abnormalities consisting of edema friability and ulceration are noted. Kilpatrick et.al.¹¹⁸ reported 10 cases of ischemic proctitis occurring spontaneously in patients who had not undergone a recent surgical procedure. It is worth noting that one of Marston's cases (Case No. 5)¹¹² had a granular rectal mucosa with a dilated colon on plain radiograph of the abdomen suggesting a diagnosis of toxic megacolon. Kilpatrick noted a rapidly evolving proctoscopic picture in this elderly, male predominated group, consisting of discrete ulcerations of pinpoint to 2 cm. size, nodular to polypoid mucosal changes and subsequent diffuse friability with grayish membrane formation. Biopsy findings were useful in differentiating an ischemic mucosa from ulcerative colitis. Therefore, the sudden onset in an elderly patient of diarrhea, abdominal pain and rectal bleeding should, even in the presence of an abnormal rectal mucosa, be compatible for the diagnosis of ischemic bowel disease. A barium enema will be useful in establishing this diagnosis, especially if it is productive of classical findings such as thumbprinting.

Treatment of Ulcerative Colitis

The principles upon which the management of patients with ulcerative colitis is based include a firm diagnosis and recognition that since the etiology of this disorder is unknown, therapy will be empirical. Attention must be given to all aspects of the patient's illness. This approach must take into account social factors, activity, diet, nutritional status (the technical capacity for effective and safe intravenous hyperalimentation),¹¹⁹⁻¹²⁰ the etiology and correction of anemia,¹²¹⁻¹²² the state of hydration and serum electrolytes including less commonly determined medications such as magnesium.¹²³ A search for aggravating factors such as milk intolerance, liver disease, hypo- or hypercoagulable states,¹²⁴⁻¹²⁵ sepsis resulting either directly from the active

JAMES L. FRANKLIN, M.D., is affiliated with the University of Chicago, Pritzker School of Medicine, Department of Medicine, Section of Gastroenterology.

JOSEPH B. KIRSNER, M.D., Ph.D., is also affiliated with the above school, and Section of Gastroenterology.

The Authors:

Ulcerative colitis

colitic process or as a result of an associated infection. The value of early collaboration with a surgeon during the course of an acute attack of the disease is well accepted. The physician must recognize the prognosis that the patient may be expected to carry in accordance with the extent and duration of the disease. Finally, he must understand the therapeutic armamentarium at his disposal including an indepth knowledge of its efficacy, appropriate usage and recognition of when it is not achieving its expectations. It is therefore desirable to review the scientific basis of current therapy of colitis.

Diet

Food allergy has been long thought to play a possible etiologic role in ulcerative colitis and milk in particular was singled out as an important contributor.¹²⁶⁻¹²⁷ Truelove¹²⁸ identified a group of patients who clearly benefitted from the withdrawal of milk and milk-containing products, being maintained symptom free for periods of 3-41 months. He demonstrated that they all promptly relapsed with 2-42 days after introduction of milk into the diet. Wright and Truelove¹²⁹ subsequently reported their results in a randomized study on the efficacy of a milk free diet in sustaining a remission in ulcerative colitis. Ten patients of a group of 25 were assigned to a milk free diet for a period of one year and maintained in remission while only five of a group of 24 given a dummy (milk containing) diet remained in remission.

The mechanism of milk intolerance in colitis is not clear. Lactose malabsorption measured by an oral tolerance test has resulted in a flat curve in as many as 50% of patients.¹³⁰ However, only 13% of these patients had symptoms of milk intolerance. Studies of mucosal lactase reveals a much lower prevalence of enzyme deficiency. Newcomer and McGill¹³¹ found 8.3% of colitis to be enzyme deficient compared with 6% in a control population. More recently Danish workers¹³² reported 9% lactose deficiency in their colitis patients (3-7% in their control population). Since these figures are lower than the clinical frequency of milk intolerance, some other mechanism would seem to be involved. Allergy has been considered but a clear relationship between circulating antibody titers to various dietary proteins and diet¹³³ has not been found. Similarly circulating and tissue eosinophils¹³⁴ bear no clear relationship to the introduction of milk into the diet.

Corticosteroids and Corticotrophin

Shortly after the introduction of cortisone and corticotrophin in treatment of rheumatoid arthritis, it was recognized that these agents appeared to have a beneficial effect on the course of ulcerative colitis. In a now classic series of controlled studies, Truelove and Witts¹³⁵⁻¹³⁷ proved their efficacy and answered many important questions about therapeutic usage. Patients were treated with 100 mg. of cortisone per day for a period of six weeks; 45 of 109 cortisone treated patients came into remission as contrasted with 16 of 101 patients treated with an inert preparation. Subsequent follow-up (off cortisone) of those patients in remission following their first attack revealed a higher percentage symptom free in the cortisone treated group as opposed to control group. This advantage for the treated group did not hold for the group that was brought into remission following a relapse (second attack). An advantage of corticotrophin therapy (80 units per day intramuscular) over cortisone (200 mg. per day orally) in inducing remission in an acute attack also has been demonstrated. Analysis of these data¹³⁷ reveals that the greater efficacy of corticotrophin was seen primarily in patients experiencing a relapse as opposed to an initial attack. The authors felt this advantage was offset by a greater frequency of Cushing's syndrome and mental disturbances associated with the use of corticotrophin. Evaluation of a low dose of cortisone (50 mg/day) in sustaining a remission after an acute attack of colitis failed to demonstrate its advantage over an inert preparation. The ability of large doses of cortisone to subsequently induce a remission in a patient who relapsed while on maintenance steroid therapy did not differ from the control group. In a similar randomized study, Lennard-Jones et. al.¹³⁸ were unable to demonstrate an advantage in maintenance with prednisone 15 mg. per day (5 mg. tid) over a placebo; 18 of 32 steroid treated and 17 of 30 placebo treated patients relapsed during a six month period. There is reason to believe¹³⁹ that higher doses of steroids, prednisone 15-30 mg, will be effective in sustaining remission; however, with this dosage a higher incidence of side effects can be expected.

Truelove¹⁴⁰⁻¹⁴¹ first reported the use of local cortisone therapy administered as an enema. He initially showed that the alcohol form of hydrocortisone diluted in normal saline could

be administered slowly as rectal drip and appeared to be effective in rapidly terminating an attack of ulcerative colitis. The hemisuccinate form of the steroid also was demonstrated to be effective and more soluble in water while absorbed to a lesser extent. The obvious advantage to this therapy included delivering higher doses of the drug to the involved tissue and avoiding the side effects associated with oral administration of steroids. Dilute barium administered in comparable volumes was shown to reach beyond the splenic flexure^{140,142} either by the slow drip or single dose (100 ml volume) method or administration. Double blind studies¹⁴³⁻¹⁴⁵ clearly showed local therapy with hydrocortisone hemisuccinate to be effective over an inert preparation. In patients with mild to moderate disease, Truelove¹⁴⁶ found local therapy to be more effective than 20 mg of prednisolone; 14 of 40 patients were free of symptoms on this dose of oral prednisolone as opposed to 29 of 40 on local enema therapy. A similar study published in the same year¹⁴⁷ failed to confirm these results and the authors questioned the use of the rectal drip method for outpatient therapy. An evaluation of the effectiveness¹⁴³ of rectal steroid drip over an inert preparation as maintenance therapy failed to demonstrate an advantage; however, the administration of only two treatments (weekend) per week can well be argued as having been inadequate. A controlled study¹⁴⁸ has demonstrated the effectiveness of a prednisolone (5 mg) suppository in the treatment of ulcerative proctitis.

Sulfonamides

Although a variety of sulfonamides and antibiotics have been utilized in the treatment of patients with ulcerative colitis, none have been as well studied as salicylazosulfapyridine (Azulfidine). This drug, a diazo compound of salicylic acid and sulphapyridine, was first developed in Sweden by Svartz in 1941. As with corticosteroids, it was first used in the treatment of rheumatoid arthritis and subsequently found to be effective in ulcerative colitis. The mode of action is uncertain and studies on the alteration of fecal microflora have not explained its action.¹⁴⁹ Haungren¹⁵⁰ has shown an affinity of salicylazosulfapyridine for connective tissue. Truelove and co-workers¹⁵¹ first demonstrated the efficacy of Azulfidine in terminating an acute attack of ulcerative colitis; when compared with combined prednisone orally 20 mg per day and rectal hydrocortisone drip, Azulfidine was not

as rapidly effective. Because of the known efficacy of steroids, investigators were reluctant to compare Azulfidine to an inert preparation; however, Baron¹⁵² and Dick¹⁵³ demonstrated the effectiveness of this drug over a placebo in mild distal ulcerative colitis in a properly randomized double-blind study. Misiewicz et.al.¹⁵⁴ have shown that Azulfidine in a dose of 2 gm per day was effective over a year in maintaining remission in ulcerative colitis. Twenty-four of 34 treated patients remained free of active disease as opposed to only eight of 33 patients treated with a placebo.

Anorexia, nausea and vomiting, with general malaise, have been frequent symptoms associated with the administration of Azulfidine. These often have necessitated withdrawal of the drug and would appear to be dose-related. Pancreatitis recently has been reported as an adverse reaction.¹⁵⁵ Spriggs et.al.¹⁵⁶ described three instances of Heinz body anemia in patients taking Azulfidine, and Bottiger¹⁵⁷ more recently reported an incidence of Heinz bodies in 8% of 72 patients screened for their presence, but did not find evidence in any of these patients of a hemolytic anemia. Leukopenia and rare cases of fatal agranulocytosis¹⁵⁸ have been reported.

Immunosuppressive Therapy

The nature of an immunologic disorder in etiology and pathogenesis of ulcerative colitis has been investigated intensively and has been the subject of a number of recent reviews.¹⁵⁹⁻¹⁶² Investigation of conventional parameters of immunological competence has not revealed evidence of immunosuppression by so-called immunosuppressive drugs with the dosages currently employed in treatment.¹⁶³ First reported in 1962¹⁶⁴ in the treatment of ulcerative colitis, there have been numerous small groups of patients reported in the literature treated with 6-mercaptopurine, 6-thioquanine, busulphan,¹⁶⁵ nitrogen mustard and most recently, azathioprine,¹⁶⁶⁻¹⁷⁰ Azathioprine (Imuran), the heterocyclic derivative of 6 MP, capable of inhibiting the synthesis of purines and interfering with essential sulfahydryl groups in the cell, has been utilized most frequently in the management of inflammatory bowel disease. Earlier reports utilized a dosage of 4-6 mg per kg per day and a high incidence of side effects were noted. Subsequent reports employing a lower dose range of 2-3 mgm per kg, have yielded comparable clinical results with a lower incidence of side

Ulcerative colitis

effects. Remission induced in patients refractory to or deteriorating on conventional therapy and an important steroid-sparing effect have been observed. The most dramatic results with this drug have been reported in Crohn's disease,¹⁷¹⁻¹⁷² where multiple fistulas have been observed to heal. These reports, however, are not entirely confirmed.¹⁷³ Reports of lymphomas developing in transplant patients on this drug have appeared and the subject of immunosuppression and cancer¹⁷⁴ is relevant to the long-term usage of this form of therapy.

It is clear that appropriately conducted controlled studies comparable to those already discussed must be performed in order to establish the efficacy of this form of therapy. Two such studies, in ulcerative colitis and regional enteritis, are currently underway at the University of Chicago.

Surgical Therapy

The two dominant trends in surgical therapy for ulcerative colitis have been to operate both more frequently and earlier in the course of the severe attack. There is general agreement in the literature that surgery performed under emergency circumstances carries with it a 20-25% mortality while elective intervention is associated with a 3% mortality.¹⁷⁵⁻¹⁷⁷ These conclusions are based largely on consecutive series, as in the case of Goligher et.al.¹⁷⁸ where prior to 1963 a policy of observing patients up to 10 days during an acute episode resulted in an 11% mortality in contrast to a figure of 1.3% obtained after 1962 when surgery was advised if medical therapy in three to four days failed to yield conclusive results; the conclusion of these authors has been widely accepted.

The procedure most frequently employed is that of ileostomy with complete proctocolectomy. Aylett¹⁷⁷ has reported excellent results with total colectomy and ileorectal anastomosis either in one or two stages. His results have been recently confirmed by another center.¹⁷⁹ This procedure has not been widely accepted¹⁸⁰ and particular concern has been expressed over retaining a segment of bowel capable of perpetuating disease and subject to a continued cancer risk. Turnbull¹⁸¹ recently has described a combination of ileostomy and transverse colostomy, retaining the colon to be removed in a second stage, for toxic megacolon with wall-off perforations. It is his belief that this will avoid surgical disruption of walled-off perforations and associated peri-

toneal contamination, thereby reducing the mortality associated with surgery in this condition.

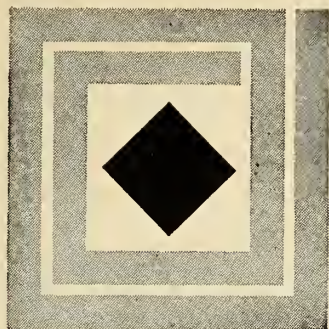
Indications for surgery have included chronic recurrent disease preventing reasonably normal life, and severe acute attack (with or without megacolon) unresponsive to intensive medical therapy, a suspicion of carcinoma, perforation of the colon and severe hemorrhage. Severe growth retardation in children has been an indication for surgery at the University of Chicago.⁶⁵ The issue of prophylactic colectomy to prevent carcinoma for those patients with disease of greater than 10 years duration and total colonic involvement is unsettled although many patients in this category will have developed an associated indication for surgery. Prophylactic colectomy has not been followed at the University of Chicago and patients individualized with regard to the timing of surgery.

While over 70% of patients successfully treated enjoyed restoration of health,¹⁸² the recovery is not uneventful.¹⁸³ Approximately 15% of patients require ileostomy operations within 10 years. Complications have included: obstruction, prolapse or retraction of the stoma, fistula or abscess formation, failure of perineal closure, prestomal ileitis,¹⁸⁴ uric acid nephrolithiasis,¹⁸⁵⁻¹⁸⁷ and most frequently, excoriation of other skin around the stoma.¹⁸² There is general agreement that modern appliances, participation of a trained stomal therapist and the aid of groups such as the ileostomists have facilitated patient acceptance and adjustment to this procedure.

Conclusion

The study of patients with ulcerative colitis continues to expand our concept of this disease as a systemic illness as new facets of the disease are recognized. Many questions remain about medical and surgical management which can only be answered through properly designed studies similar to those described in this review. The most challenging problem remains the etiology and pathogenesis of inflammatory bowel disease. The answer may be beyond our current understanding of the mechanisms of disease and may await the discovery of a new concept in pathology. The history of diseases now well understood tells us that only when the pathogenesis of ulcerative colitis is known will we begin to design therapy specific for its prevention or cure.

(Continued on page 396)



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



Figure 1.

This is a 21-year-old patient who was discharged from the Army because of the appearance of his chest. He had known that a brother had also been told that he had chest trouble.

What's your diagnosis?

1. Sarcoid
2. Miliary Tuberculosis
3. Histiocytosis
4. Pneumoconiosis
5. Pulmonary Alveolar Microlithiasis

(Answer on page 396)



surgical grand rounds

EDITED BY JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of November 17, 1970.

Pancreatic transplantation

Case Report:

Dr. John Bergan: Organ transplantation began at Northwestern University Medical School in February, 1964, and our group is now following three patients who received renal transplants that year and who are surviving six years, entirely dependent for life on the function of their transplanted kidneys.

Our interest in pancreas transplantation goes back to 1964, when we were attracted to this subject by two provocative statements. The first, "Of all endocrine gland deficiencies, that of islet tissue appears to be the least easily compensated for by exogenous replacement therapy," summarizes the difficulties attending care of the juvenile diabetic. Because of our interest in vascular disease, we knew that the vascular complications of

diabetes often progress despite adequate regulation of the diabetic state and meticulous replacement therapy with exogenous insulin.

The second statement, "Self-digestion of the pancreas continues to be the major stumbling block to the success of pancreatic grafting," seemed to be the necessary challenge to stimulate laboratory activity. By the end of 1964, we had solved the problem of total pancreas transplantation in the dog using the facilities of the Surgical Research Laboratory at Northwestern. During the following year, we investigated and reported the insulin and glucose levels of functioning heterotopic pancreatic grafts and turned our attention the following year to the cause of necrotizing pancreatitis in such allografts.

Lessons learned in these early physiologic observations on function of the transplanted gland

seemed to point the way towards eventual human application of these techniques. By 1966, the auxilliary pancreas had been studied and the following year, complete physiologic studies were finished which defined the differential function of the pancreas and duodenum in the grafted state.

It was about this time that we discovered that hyperamylasemia would be a more sensitive index of rejection of the gland than hyperglycemia. All in all, the pancreatic endocrine tissue seemed more resistant to rejection than the exocrine tissue. Recognizing that further physiologic studies would be necessary but that storage of the gland for transplantation would be desirable, we performed a series of experiments in 1968 which would lead the way towards eventual storage of the gland. It was clear from these studies that pancreas storage and renal storage presented essentially similar problems. Furthermore, there was no clear cut definition of the ischemia tolerance of the pancreas. Therefore, by 1969, studies were completed which defined the tolerable normothermic ischemia of the pancreas.

The net result of these studies was that we found the pancreas to be a hardy organ which resisted ischemia relatively well and which functioned quickly in a manner which allowed normal regulation of blood glucose levels. It was true that the pancreas had autonomous function and yet, during the period before rejection took place, glucose tolerance tests were normal and the response to tolbutamide stimulation was also essentially normal.

The problem of allograft pancreatitis was related to exocrine outflow obstruction and venous outflow obstruction, both of which could be prevented in the human transplant situation.

With these lessons learned and this experience behind us, it seemed appropriate to move the locale of the studies from the Surgical Research Laboratories across the street to Passavant Hospital. A protocol for the human experiment was drawn up, modified according to the wishes of the Human Experimentation Committee, and recipients were examined. An independent evaluating committee also examined the recipients and approved those which were selected by us for eventual transplantation.

During the past six month period, we had been searching for an appropriate pancreas donor. When such a donor became available, our team was ready to move into action.

Dr. C. Andrew Heiskell: A 32-year-old, white male was admitted to Passavant in March, 1970.

He was found to have diabetes mellitus when 12-years-of-age. For the next 17 years, he had numerous insulin reactions but never developed diabetic coma. At age 29, he developed pulmonary edema, and investigation revealed renal disease and hypertension. The renal disease progressed, and he had several episodes of acute congestive failure. Last year his vision began deteriorating. Beginning in February 1970, he was treated by chronic hemodialysis, which he tolerated poorly, developing weakness and lethargy during the procedures. His circulatory failure increased to the point where he could only sleep in an upright position. His visual difficulties progressed to almost total blindness of the right eye. Over the first few months of 1970, he developed progressive numbness and weakness in his legs. When he was admitted in March, he was taking 34 units of Lente insulin a day, 240 milligrams of Lasix every evening and 500 milligrams of Aldomet to control his blood pressure. Physical exam revealed a blood pressure of 145/80 and a pulse of 72. He was able to read a newspaper with his left eye, but could only count fingers with the right. His heart was enlarged and a grade IV/VI apical systolic murmur was present. The liver edge was two finger breadths below the right costal margin. Lower extremities: 3+ pitting pretibial and ankle edema, severe muscle weakness and absent ankle jerks. Marked decrease in touch and vibratory sensation was noted. *Laboratory findings:* Urinalysis; 10-20 red blood cells and 2-4 hyalin casts; hematocrit, 17; total protein 5.1 gm; calcium 8.1 mgm%; creatinine 8.3 mgm%; BUN 66 mgm% and creatinine clearance 44 ml/min; skeletal X-rays revealed osteoporosis; chest X-ray showed 20% increase in heart size; EKG showed marked ST segment and T-wave abnormalities. During his first hospitalization he required hemodialysis 2 to 3 times a week and careful diabetic management. His insulin requirement increased from 32 to 64 units per day, and his Lasix to 320 milligrams per day. He was presented to the Transplantation Board for review as a candidate for kidney and pancreatic transplantation. After thorough review and discussion with the patient as to the experimental nature of this procedure, he was accepted as a possible recipient. After his discharge in April he was admitted twice, each time requiring approximately six weeks hospitalization, and frequent hemodialysis. His blindness had progressed and he had required more medication to control his blood pressure. He was admitted again September 4, with progressive edema and shortness of breath. His medication included 960 mil-

Pancreatic transplantation

ligrams of Lasix, 48 units of Insulin and eight tablets of Amphogel daily. *Physical examination revealed:* blood pressure 210/100; positive findings included marked peripheral edema; distended neck veins; a grade III/IV apical systolic murmur; creatinine 12.8 and BUN 114 mgm%. He was treated vigorously with diuretics and hypertensive medications and hemodialysis, and lost approximately 30 pounds. He was subjected to subtotal parathyroidectomy for tertiary hyperparathyroidism on October 30. On November 4, he was relatively well with a hematocrit of 19, BUN of 99 mg and creatinine 12.6 mgm%. On November 5, a donor became available for kidney and pancreas transplantation.

Dr. Frederick Merkel: The donor became available at Grant Hospital as a result of brain death, the patient being a cardo-pulmonary preparation. The kidneys were removed first, one kidney being implanted into the recipient here at Passavant while another was stored for later use at Veterans' Hospital. While the renal transplant was being done, the dissection of the donor pancreas was carried out. As Dr. Bergan pointed out, one of the critical aspects of the pancreatic transplantation is how the donor operation is performed. The donor procedure is carried out by first removing the stomach, and discarding it, and then by removing the small intestine, and discarding it. The pancreas is thus left alone in the retroperitoneal area with its loop of duodenum and the spleen attached. The portal vein is carefully skeletonized and the hepatic arteries are ligated, and divided at their branch points, so that the gastroduodenal and superior pancreaticoduodenal vessels are not compromised. Also the pyloric vessels are very carefully preserved so that when closure of the duodenum is accomplished, there is absolutely no ischemia because this has been the site of duodenal breakdown in previous transplants. The duodenum is closed, as in the Billroth II operation, with an extra layer of sutures. A Carrell patch of aorta is prepared, including both the celiac axis and the superior mesenteric artery. The spleen is used as a handle to separate the body and tail of the pancreas from the posterior abdominal wall. The spleen is then amputated. This maneuver avoids trauma to the gland.

While this dissection was being carried out, the left iliac fossa was opened in the recipient, and the iliac vessels were completely skeletonized from their take-offs from the aorta and the vena cava to the inguinal ligament. This is necessary

so that there will be no venous compression.

The vascular anastomoses are carried out by implanting the Carrell patch of aorta into a similar defect made in the common iliac artery. End to side anastomosis of the portal to common iliac vein is next carried out. The blood supply to the graft is then restored.

The first human pancreas transplant was done without the associated duodenum. That was a duct ligated preparation and some fibrosis occurred with time. The patient died of pulmonary embolus, and other complicating features. But we were afraid that the long term results would be prejudiced by fibrosis, so that the rest of the transplants were done as pancreaticoduodenal grafts.

Our first grafts were carried out bringing the distal duodenal stoma out onto the abdomen, but this proved to be an inconvenience with up to two liters of pancreatic juice spilling out on the abdominal wall every day. Since then an internal hook-up has been carried out using a Roux-en-Y loop of recipient jejunum or a direct connection as was done in our recipient.

The patient at two weeks post-transplant has required no insulin. Prior to transplant the patient required an average of 45 units of NPH insulin a day. Early morning fasting blood sugars were perfectly normal, later in the day they go up higher, but do not exceed what we see in our other transplants who are on the same amount of immunosuppressive drugs. Recently an increase in the blood sugar occurred, but the patient was undergoing a renal rejection necessitating marked increase in the steroids, and we believe that this increase in blood sugar is due to the increased steroids. Serum amylase values initially were elevated, but rapidly came down to normal and remained under 100. The BUN reached a low of 22, after which the rejection reaction occurred which is currently being treated vigorously.

Radiologic studies were performed by Dr. Nudelman to evaluate the state of both grafts.

Dr. Earl J. Nudelman: The right femoral artery was chosen because of the anastomosis of the patch graft to the left iliac artery. The catheter was placed above the aortic bifurcation. The transplanted kidney in the right iliac fossa is well visualized. There is a very slight narrowing at the site of anastomosis. At the time of this angiogram there is no radiographic evidence of rejection. (Fig. 1) The intrarenal small vessels



Figure 1. Arteriogram showing the transplanted renal (K) and pancreaticoduodenal graft (P). Note the renal artery is anastomosed end to end to the patient's R. hypogastric artery (arrow) and a Carrell patch (arrow) of donor aorta bearing the celiac axis and superior mesenteric artery.

branch normally. The kidney is seen "en-face" and appears large. There may be some edema. At the site of the patch graft, there is slight narrowing. The celiac and superior mesenteric vessels are well visualized. The hepatic artery is ligated just distal to the gastro-duodenal artery. The ligated splenic artery is also well seen. The transplanted duodenal wall shows a faint blush, the valvulae are separated due to edema. Long bone films show extensive vascular calcification.

Barium studies show edema in the transplanted duodenal segment and at the site of small bowel anastomosis the transplanted duodenal loop is only partially filled (Fig. 2).

Dr. Bergan: One of the lessons learned in the human experiment has been that the renal rejection which accompanies pancreas transplantation is early and severe. Our experience now confirms the observations of the Minnesota group; the kidney rejection episode is profound and resists conventional treatment. However, it is also clear that such rejection can be overcome and a state of desirable host-graft nonreactivity can be achieved.

The logical conclusion to be reached from this experience is that the pancreas should be transplanted alone, without the additional burden of a renal graft. It is our intention to perform this operation on our next pancreas recipient.

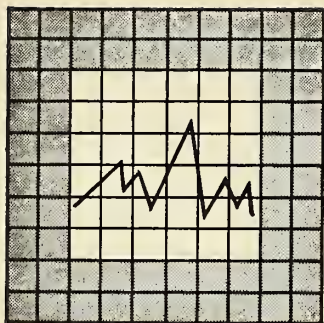
Dr. John Beal: Could one support the concept that there is a difference in the rejection potential of different organs by virtue of the fact that this patient is apparently rejecting the kidney but not his pancreas?

Dr. Bergan: The differential features of the rejection could be explained by a number of different theories. My own belief is that renal and pancreas rejection proceed in parallel, along with that of the duodenum. However, manifestations of rejection of each organ are quite dissimilar.

(Continued on page 396)

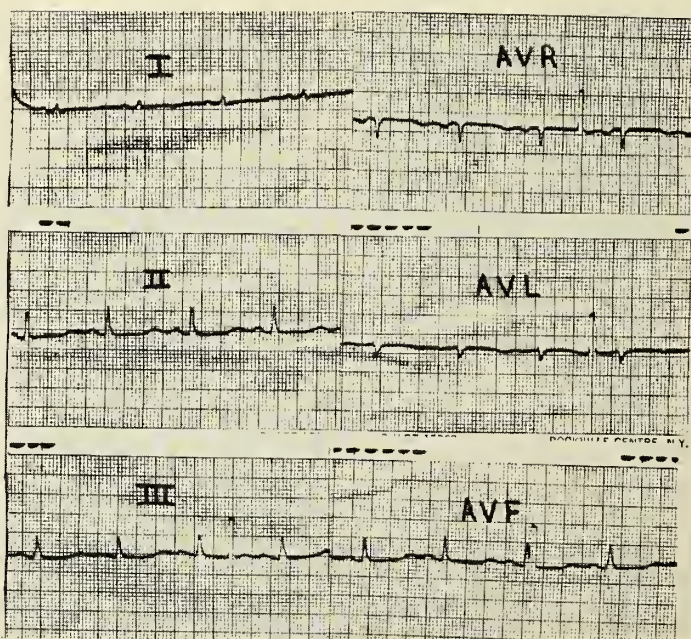


Figure 2. Upper gastrointestinal contrast study demonstrating the patient's own jejunum (J) and the duodenal segment (D) of the pancreaticoduodenal allograft.



ekg of the month

JOHN R. TOBIN, JR., M.D., M.S., RINGAUDAS NEMICKAS, M.D.,
PATRICK SCANLON, M.D., JOHN F. MORAN, M.D. AND JAMES
V. TALANO, M.D./SECTION OF CARDIOLOGY,
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This 45-year-old male had been on several antiarrhythmic drugs on and off for several years for palpitations. He presently enters the hospital very depressed and states that he has taken an overdose of one of his medications. Physical examination is unremarkable.

Questions: (One or more of the choices may be correct.)

- A. The electrocardiogram reveals:
 1. Atrial flutter.
 2. Sinus rhythm.
 3. Prolonged Q-T interval.
 4. Large U waves.
 5. Intraventricular conduction delay.
- B. The offending drug might be:
 1. Digitalis.
 2. Quinidine.
 3. Potassium.
 4. Procaineamide.
 5. All of the above.

(Answer on page 423)

Measles

In previously vaccinated children in Illinois

TWO RECENT MEASLES outbreaks in northern Illinois with a total of 271 cases were investigated epidemiologically. Nearly all cases occurred in unvaccinated school children, despite a state law requiring measles immunization of all pupils entering school.

Fifty-four cases—49 of them in school-age children—occurred in Greenwood township. The level of previous immunity against measles in schoolchildren there was 75.7%. Another 217 cases—192 of these in school children—occurred in the town of Round Lake. In that district 43.3% of school children were immune to measles. No spread of measles occurred in the McHenry school district, where 90.4% of children were immune, nor in two nearby private schools with high levels of immunity.

This experience emphasizes the need for maintaining high levels of immunization against measles if spread of the disease is to be prevented. Physicians, public health workers, and school health officials must be aware of the importance of measles vaccination.

Introduction

Since 1967 measles has again become a significant disease in the United States. More cases of measles have occurred in the current epidemiologic year* than in any since the drive to eradicate measles began in 1966 (Fig. 1).¹ Some of the 1970-71 measles cases occurred in children previously vaccinated against measles. It therefore became necessary to re-evaluate the durability of protection provided by live, attenuated measles-virus vaccine.

In this study, the protective efficacy of measles vaccine was examined in two recent outbreaks in Northern Illinois. Initially in these epidemics

there was concern about possible widespread vaccine failure. Investigation demonstrated, however, that nearly all cases of measles occurred in unvaccinated children.

Locality and population

The City of McHenry, population 6,772 (1970 census), is located in northeastern Illinois near the Wisconsin line. It serves as the business center for eastern McHenry County, population 111,555, and for adjacent rural areas of Lake County, population 382,638.

Methods of Study

Data on the previous incidence of measles were obtained from the records of the Lake and McHenry county health departments.

Information on measles cases in McHenry

*The measles epidemiologic year (EY) begins with the calendar week 41 and ends with week 40 of the following year.

Measles in vaccinated children

County and in the western townships of Lake County was sought by calling physicians, searching school and nursery records, and asking families of patients for names of contacts or other patients. Vaccine histories were obtained by interview or questionnaire survey of parents and were corroborated whenever possible by health department or physicians' records.

Immunization surveys were conducted in five school districts: two with measles outbreaks and three controls. In the districts with up-to-date school health records, random records were sampled. In districts where doubt of the records' completeness existed, parents were surveyed by a supplemental questionnaire. Vaccine efficacy was calculated by the formula:

$$\text{EFFICACY (\%)} = \frac{\text{Illness Rate for Unvaccinated minus Rate for Vaccinated}}{\text{Rate for Unvaccinated}} \times 100$$

Clinical picture

The illness was clinically compatible with measles. The typical patient had a 4- to 5-day prodrome with high fever, cough, coryza, and conjunctivitis, followed by the appearance—first on the face—of a blotchy, bright red maculopapular rash. Koplik's spots were seen on many patients. Defervescence usually occurred two to three days after the appearance of rash, but the rash lasted five to seven days.

Two cases of measles with pneumonia were reported. A history of earache or diagnosed otitis media was obtained from 11 (6.8%) of 163 interviewed patients. One case of measles with encephalitis occurred. No deaths were reported.

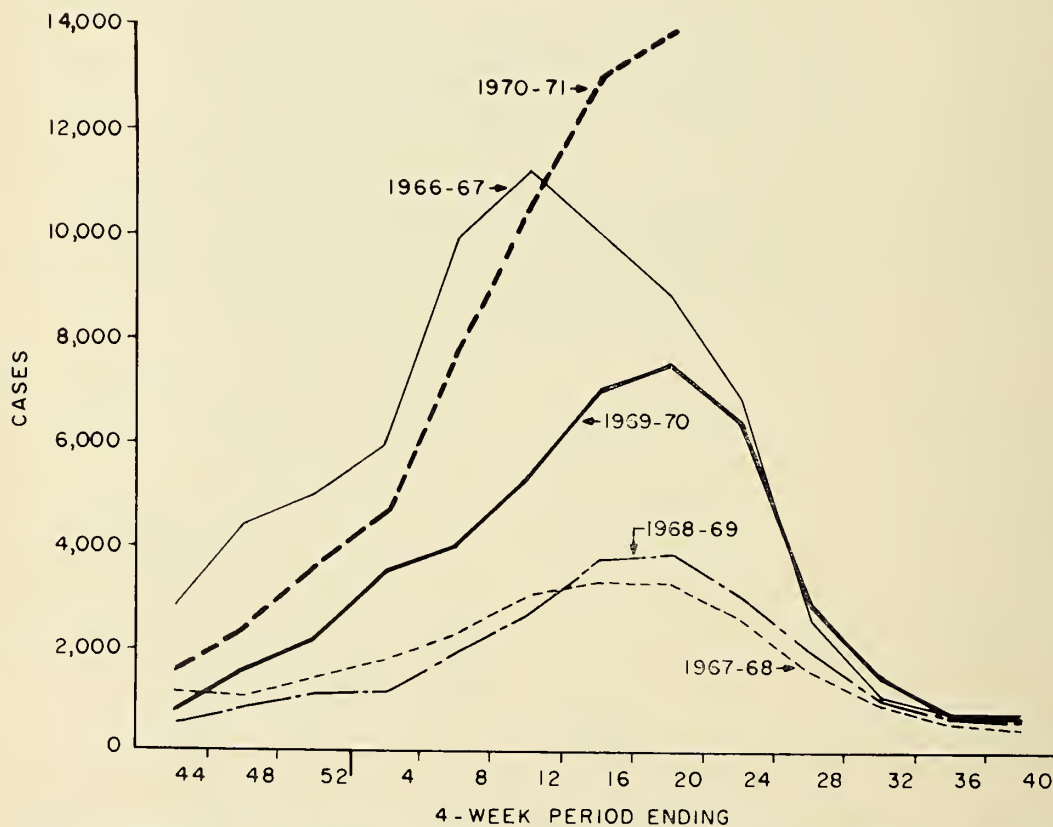


Fig. 1. Reported cases of measles by four-week period, U.S.A., for epidemiologic year 1970-71 compared with 1966-67, 1967-68, 1968-69, and 1969-70.

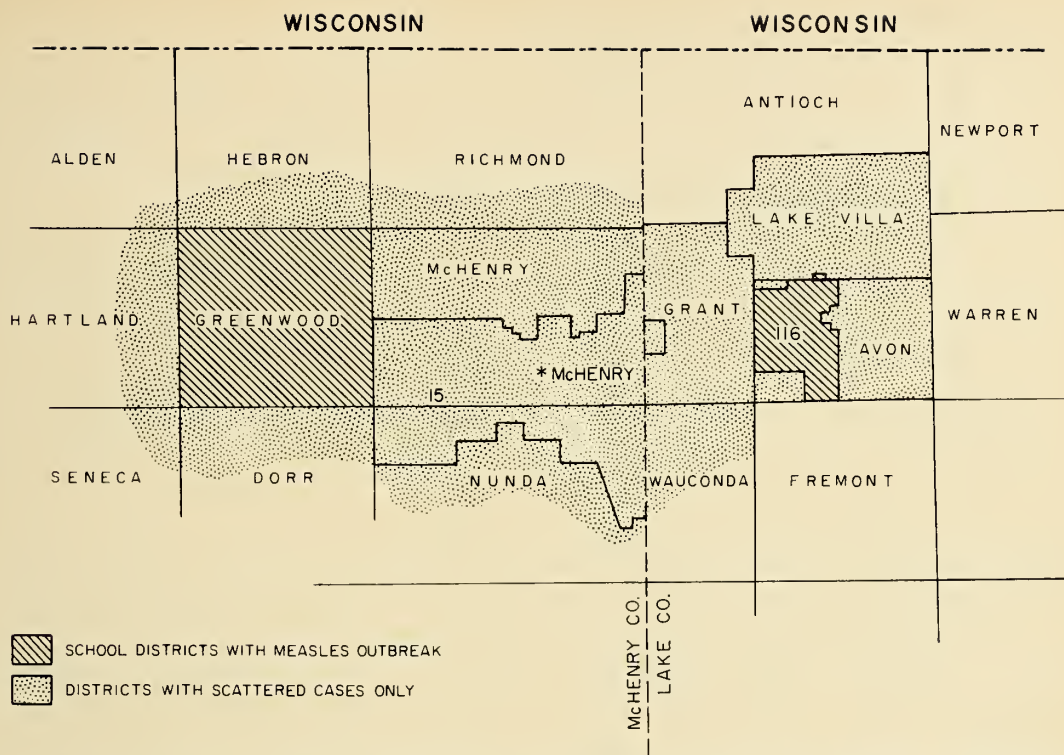


Fig. 2. Locations of measles outbreaks by school district in Lake and McHenry Counties in Illinois, January-March, 1971.

The outbreaks

A total of 298 cases of measles occurred in the townships around McHenry between January 1 and March 31, 1971; 271 of these cases (91.0%) occurred in two distinct outbreaks—one in rural Greenwood Township in McHenry County and the other in semi-rural Round Lake (School District 116) in western Lake County (Fig. 2). All other nearby areas reported only scattered cases.

A. The Greenwood Outbreak

In Greenwood, 54 cases occurred between February 5 and March 31 (Fig. 3). Forty-nine (90.6%) of these cases were in school children, and the overall attack rate in grades kindergarten through fifth was 13.3%. Attack rates were highest for children in kindergarten and grades first and second (Table 1). In this rural area there was no measles spread by preschoolers, and all preschool cases could be traced to contact with school children.

Review of school health records in Greenwood showed that 75.7% of elementary school students were immune to measles before the out-

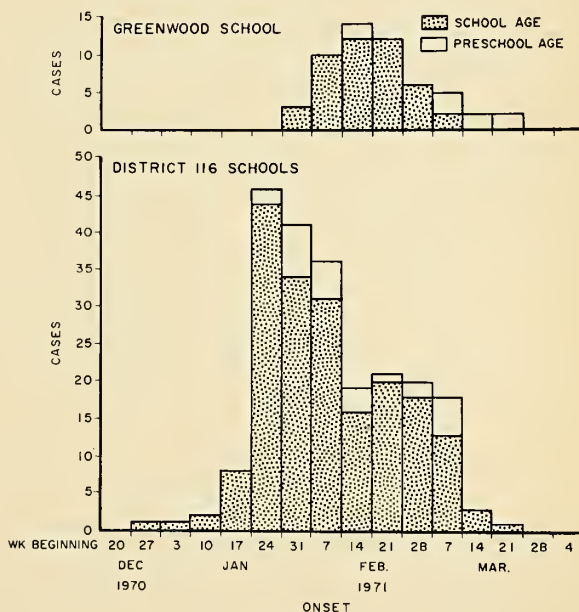


Fig. 3. Measles cases by date of onset in Greenwood School—McHenry County—and District 116 schools—Lake County—Illinois, December 20, 1970-March 31, 1971.

Measles in vaccinated children

Table 1

Measles Attack Rates by Grade in Greenwood School, McHenry County, Illinois, February-March 1971

Grade	Census	No. of Cases	Attack Rate (%)
K	67	16	23.9
1	57	15	26.3
2	63	11	17.5
3	72	2	2.8
4	51	1	2.0
5	59	4	6.8
Total	369	49	13.3

Table 2

Measles Attack Rates by Vaccination Status—Greenwood School, McHenry County, Illinois February-March 1971

	Est. No. of Children	No. of Cases	Attack Rate (%)
Vaccinated	250	9	3.6
History of Measles	30	0	0
Unvaccinated and Susceptible	89	40	45.0
TOTAL	369	49	13.3

break; 8.1% of children in the sample had previously had measles, and 67.6% had received measles vaccine. These data were confirmed by a questionnaire survey, to which 251 (81.0%) of 310 parents responded.

Nine cases of measles in Greenwood occurred in previously vaccinated school children; these children had been vaccinated at separate times by various physicians. Four of the nine patients had received measles vaccine before age one with immune globulin. The attack rate for previously vaccinated children was 3.6% (Table 2). This rate would be lower if the children vaccinated before age one were discounted. The attack rate for unvaccinated susceptible children was 45.0%. From these data a vaccine efficacy of 92.1% was derived.

B. The Round Lake Outbreak

In Round Lake (School District 116), 217 cases of measles occurred between January 1 and March 31 (Figure 3). One hundred ninety-two (88.5%) of these cases were in elementary-school children, with highest attack rates for the kindergarten and grades one through four (Table 3). The overall attack rate in the elementary schools in District 116 was 9.5%. The first cases occurred in two sisters who attended kin-

dergarten and second grade, respectively. These children had been exposed to measles in Chicago, and their symptoms developed in the first week of January.

The prior level of measles immunity in Round Lake school children was estimated from a review of school health records and a questionnaire survey of parents to be 43.3%. A past history of measles was given by 16.7% and measles vaccination was reported by another 26.6%. From these data, we estimated that 335 of the 2,014 children in grades kindergarten through six had previously had measles, that 535 had received vaccine, and that 1,144 were susceptible (Table 4).

Nine documented cases of measles occurred in previously vaccinated school children in Round Lake. Three of these children had received vaccine before age one with measles immune globulin. The attack rate for vaccinated children was 1.7% (Table 4), and for unvaccinated susceptibles 15.9%. Vaccine efficacy was calculated to be 89.0%.

Table 3

Measles Attack Rates by Grade in School District 116, Round Lake, Illinois, January-March 1971

Grade	Census	No. of Cases	Attack Rate (%)
K	311	44	14.1
1	292	54	18.5
2	285	28	9.8
3	271	27	10.0
4	317	31	10.0
5	288	5	1.7
6	250	3	1.2
Total	2,014	192	9.5

Table 4

Measles Attack Rates by Vaccination Status in School District 116, Round Lake, Illinois, January-March 1971

	Est. No. of Children	No. of Cases	Attack Rate (%)
Vaccinated	535	9	1.7
History of Measles	335	0	0
Unvaccinated and Susceptible	1,144	183	15.9
TOTAL	2,014	192	9.5

Table 5
Prior Measles Immunity Levels and Attack Rates by School,
Lake and McHenry Counties, Illinois,
January-March 1971

School	No. of Children Grades K-6	% of Children with Prior Measles Vacc.	% of Children with Prior Vacc. or Past History of Measles	Attack Rate (%)
District 116 (Round Lake)	2,014	26.6	43.3	9.5
District 15 Greenwood (McHenry)	369	67.6	75.7	11.7
St. Thomas—Catholic	3,200	79.8	90.4	0.1
St. Paul—Catholic	252	61.2	76.8	0
Lutheran	60	100.0	100.0	0

Controls

Three school districts near Greenwood and Round Lake had low measles attack rates. Only three of 3,200 elementary school students in School District 15 had measles. This district includes the City of McHenry and lies between Round Lake and Greenwood (Fig. 2). Review of school health records indicated that the prior level of measles immunity in District 15 was 90.4%. In a sample of 84 children 67 (79.8%) had received measles vaccine, and nine (10.5%) gave a history of measles.

No cases of measles occurred in two Round Lake private schools (a Lutheran school and a Catholic school) with a combined enrollment in kindergarten and grades one through six of 312 pupils. Contact between children in these schools and children in the District 116 public schools is close and frequent; all of the schools draw children from the same area, and many who go to private school play with children in public school. Also, some private-school children ride to and from school on the public school buses. Review of health records indicated that the level of immunity in the Lutheran school was 100%. In the Catholic school a questionnaire survey of parents of 156 children indicated that the immunity level was 76.8%; parents of 147 children (94.3%) responded; 15.6% gave a history of measles, and 61.2% had received measles vaccine.

Discussion

The critical factor underlying the spread of measles in these outbreaks was inadequate immunization of susceptible school children. Measles spread where school immunization laws were not enforced. Thus in the Greenwood and Round Lake schools, where immunity levels were low, measles spread widely, but in School

District 15 and in the Lutheran school, where more than 90% of children were protected (Table 5), no spread occurred. It is not clear why no measles cases were found in the Catholic school, where only 76.8% of children were immune; there may have been less exposure there than suspected.

Laws requiring measles immunization prior to school entry exist in 21 states, including Illinois.² Since measles spread when unvaccinated children are grouped together for the first time in their lives, enforcement of school immunization laws has been very helpful in halting spread of measles in suburban and rural areas,³ but has been less effective in cities, where many children mix as preschoolers in nurseries and day-care centers.⁴ Enforcement of the Illinois school immunization law would almost certainly have prevented the spread of disease in these outbreaks where 241 (88.7%) of 271 cases occurred in school-age children.

The problem of inadequate immunization against measles is nationwide. In 11 measles outbreaks evaluated in the past eight months by the Center for Disease Control, spread of measles has been shown to occur almost exclusively among unvaccinated children. The 1970 United States Immunization Survey shows that levels of measles vaccination have been declining in all parts of the country in the past two years: overall levels of measles vaccination in children age one to four years have fallen from 61.4% in 1969 to 57.2% in 1970. In addition, vaccine distributors' data, as reported to CDC, indicate that measles vaccine distributions has fallen from 7.9 million doses in 1966 to 4.6 million doses in 1970.

PHILIP J. LANDRIGAN, M.D., is a medical epidemiologist in the Epidemic Intelligence Service of the Center for Disease Control in Atlanta, Georgia. A specialist in pediatrics, Dr. Landrigan received his M.D. from Harvard Medical School in 1967.



Measles in vaccinated children

In these outbreaks, physicians initially thought that the majority of cases were occurring in children who had been vaccinated against measles. Investigation showed, however, that attack rates for unvaccinated school children were 10 to 12 times higher than for their vaccinated classmates. The attack rates of 3.6% and 1.7% in the vaccinated children are not excessive and are consistent with the 3-5% failure rate that serologic studies⁵ have indicated may occur with live, attenuated measles-virus vaccine. Perhaps the early impression of widespread vaccine failure reflected the fact that children vaccinated by private physicians tended to go to their physicians when they got sick, while unvaccinated children did not.

Seven of the 18 previously vaccinated children who contracted measles in these outbreaks had received live measles vaccine with immune globulin before one year of age. Many of these children had been inoculated between March 1963 and February 1965, when the Public Health Service Advisory Committee on Immunization Practices recommended that measles vaccine be administered with immune globulin at age nine months.⁶ High attack rates in groups of such children have been noted in several recent outbreaks.^{7,8} ◀

References

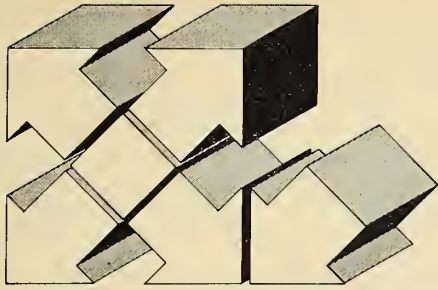
1. Center for Disease Control: *Morb. and Mort. Wkly. Rep.*, 20 (26):237, July 3, 1971.
2. Amendment to Section 27-8 of the Illinois School Code; 26 August 1967.
3. Nader, P. R., Sills, J. R., Calafiore, D., Warren, R. J.: "Measles epidemic control in Mason County, Kentucky, 1965 to 1966," *JAMA*, 200: 811-814, 1967.
4. Hardy, G. E., Jr., Kassanoff, I., Orbach, H. G., et al.: "The failure of a school immunization campaign to terminate an urban epidemic of measles," *Amer. J. Epidem.*, 91:286-293, 1970.
5. Katz, S. L., Kempe, C. H., Black, F. L., et al.: "Studies on an attenuated measles-virus vaccine: VIII. General summary and evaluation of the results of vaccination," *New Eng. J. Med.*, 263: 180-184, 1960.
6. "Statement on the status of measles vaccines, ad hoc advisory committee on measles control," *JAMA*, 183:1112-1113, 1963.
7. Baratta, R. O., Ginter, M. C., Price, M. A., et al.: "Measles (rubeola) in previously immunized children," *Peds.*, 46:397-402, 1970.
8. Center for Disease Control: *Morb. and Mort. Wkly. Rep.*, 20 (13):115-116, Apr. 3, 1971.

Acknowledgment

The assistance of Norman J. Rose, M.D., and J. Lyle Conrad, M.D., is gratefully acknowledged.

Responding to patients' needs

A study of 12,835 patient visits to 15 Massachusetts practitioners indicated that while illness was the reason for 75% of the visits, nonsickness was the most common diagnosis recorded by the physician, accounting for almost 25% of the diagnoses. Fifty-two percent of the sick patients had multiple diagnoses and 20% raised additional problems about other family members. Visits were coded using the International Classification of Disease (ICD). The ICD was intended primarily as a classification of hospital patients and proved inadequate for classifying primary care. There was a correlation between the physician's age and that of his patients with the youngest physicians having the higher percentage of younger patients. The study findings suggest that some tasks proposed for the new family physician are being accomplished although none of the participating physicians were specifically trained for family medicine. The future family physician will almost certainly require different training if he is to effectively respond to the needs of his patients. (J. Whitney Brown et al.: "A Study of General Practice in Massachusetts," *JAMA* 216:2, April 12, 1971, pgs. 301-306.)



trauma center

BY JOHN G. RAFFENSPERGER, M.D./CHICAGO

Management of— Abdominal trauma in children

MOST ABDOMINAL INJURIES in children result from blunt trauma. A seemingly trivial or even forgotten incident, such as a "belly flop" on a sled may cause a severe intraabdominal injury. Repeated questioning may be necessary to elicit a forgotten injury which explains an obscure abdominal pain, anemia or even frank shock. On the other hand, many children with blunt abdominal trauma have a concomitant head, chest, or extremity injury resulting from an automobile accident or a bad fall.

Physical examination

You must examine an acutely injured child rapidly, but systematically. During the first few minutes remove the child's clothing, and while you take the history, evaluate his airway, level of consciousness, and vital signs. Look for tenderness over the cervical spine and passively move the head and neck, ask the child to move all extremities and check his sensation. Examine for instability or tenderness over the rib cage, auscultate the chest, and look for tell-tale bruises or an overlooked penetrating injury. The pelvis should be compressed at the symphysis pubis and over the iliac crests. Finally, move and palpate all the extremities. These rapid maneuvers

will detect obvious fractures, a compromised airway, and obvious blood loss.

Abdominal pain, tenderness or distention may clearly indicate an intraabdominal injury, while superficial bruises, hematuria, fractures of the lower ribs, an unexplained tachycardia, or pallor are also signs suggestive of intraabdominal trauma. On the other hand, visceral injuries may present very subtle signs which are easily overlooked unless a careful plan of observation is followed. At any suggestion of an abdominal injury, blood is drawn for a hematocrit, serum amylase, and a type and crossmatch; then intravenous lactated Ringer's solution is started through the same needle. Insert a nasogastric tube to lavage the stomach, particularly if the

Abdominal trauma

child has had a recent meal. If he cannot void, a catheter is passed and the urine examined for blood. If the child's vital signs indicate hemorrhage, insert a central venous pressure (C.V.P.) catheter through an arm cutdown.

When the child has severe associated trauma to his chest or head, one cannot always rely on subjective complaints and physical findings. Even in this situation, however, it is often possible to detect abdominal pain, because the child will moan when his abdomen is palpated but does not respond when examined elsewhere.

Usually the child's condition will permit roentgenograms and other studies; however, children in shock should not be taken to the X-ray department for needless roentgenograms of their skull or extremities. The child should be evaluated clinically, treatment started, then the decision made as to what studies are needed.

The upright roentgenogram of the abdomen and a chest film may demonstrate free air in the peritoneal cavity, an unsuspected hemothorax or pneumothorax, acute gastric distention, or a fractured pelvis overlooked on the initial examination. An intravenous pyelogram should be done if there is hematuria or flank tenderness; hematuria with lower-abdominal pain or a pelvic fracture demands a cystourethrogram. Careful planning will allow you to obtain all the necessary roentgenograms in one trip to the radiology department. To avoid needless delay, the responsible surgeon and radiologist should view the films while the child is still on the X-ray table.

The initial clinical, laboratory and roentgen examinations may make a clear diagnosis, or at least provide indications for a laparotomy. If not, frequent observations of the abdomen, vital signs, hematocrit, and urine volume are in order. It is wise to measure the abdomen at the umbilicus to document abdominal distention. Tenderness is the single, most valuable sign of intra-abdominal pathology, but you must do careful, gentle palpation and develop good rapport with the child to evaluate tenderness correctly. It is difficult to distinguish intra-abdominal pain from a contused abdominal wall, but generally, if the signs can be elicited remotely from the contused area or if the tenderness is spreading, an operation is usually indicated. A child may lose considerable blood with little change in his blood pressure, and of course the hematocrit does not immediately reflect blood loss. A rising pulse

rate and a falling central venous pressure (C.V.P.) are the most valuable indices of hemorrhage. A head injury may obtund the child so that it is difficult to evaluate abdominal tenderness, and the vital signs may be altered by fractures or external hemorrhage.

When there are clear signs of peritoneal irritation, a paracentesis is unnecessary. The best indication for a "tap" is in an obtunded child who has had a head injury, and who also may have abdominal trauma. Unfortunately, in an awake, alert child a "negative" tap leads to a false sense of security, and his pain and fright may make further abdominal examination more difficult.

The aspiration of non-clotting blood indicates a ruptured spleen, liver or mesentery. A retroperitoneal hematoma may also leak through into the peritoneal cavity. Bile-stained or cloudy fluid is diagnostic for rupture of the biliary tract or intestine.

The spleen

Initially there may be only mild tenderness and a little guarding in the left upper quadrant, perhaps referable to an abrasion or contusion of the abdominal wall. If this tenderness becomes more severe, or if it spreads to other areas of the abdomen, the child very likely has a ruptured spleen. Some will have pain referred to the left shoulder, particularly if the foot of the bed is elevated, or as you bimanually palpate the flank (Kehr's sign). Repeated examinations of the abdomen, with serial observations of the vital signs and hematocrit, will allow a correct diagnosis to be made in a few hours and prior to serious blood loss. A drop in the hematocrit of three or four points is equivocal and may be due to intravenous fluids. The hematocrit is also unreliable when there is an associated injury, such as a fractured femur, as blood is lost into the soft tissue of the thigh.

In a delayed rupture of the spleen, minor trauma causes a subcapsular hemorrhage, which later goes on to complete rupture, with free blood in the peritoneal cavity. Classically, the child was injured, perhaps seen by a physician, and sent home. A week or two later after another trivial accident he goes into shock, and at operation or autopsy he was found to have a large subcapsular hematoma of the spleen which had rebled. Abdominal aortography and radionuclide scanning with ^{99m}Tc perperthechne-

tate sulfide (Fig. 1) is often helpful in diagnosing splenic injuries when clinical findings are too subtle for a definitive diagnosis.

Liver injuries

Right-sided abdominal pain, tenderness and guarding are the most common physical findings in children with significant liver injuries. A small laceration on the posterior surface of the right lobe may result in minimal abdominal tenderness when the child is first seen by a physician. The initial vital signs of these children on admission may not be particularly remarkable. The lowest recorded admission blood pressure among our 13 patients with liver injuries was 70/40 in a nine-year-old boy who had a massive stellate laceration of the right lobe of the liver, a fractured humerus, extensive scalp laceration and hematuria. He had 800 ml of blood in his peritoneal cavity, and he died from massive blood loss on the operating table. Once again, a child's blood pressure is the poorest index to his blood loss. A rapid thready pulse, cool extremities, and signs of intense vasoconstriction are far better indications of shock. Often these children will have a depressed sensorium and are thought to have a head injury. All our children with liver injuries have had positive abdominal paracenteses.

Hematemesis following abdominal trauma always brings up the question of hematemesis. Unfortunately, the abdominal injury may have been minimal and the diagnosis is delayed. In these situations, one example is instructive as is shown in the following case:

Case History:

One busy July night the orthopedic intern admitted a five-year-old boy with a fracture of the right femur. One week later, the child complained of upper-abdominal pain and vomited a large amount of blood. After being transfused with a unit of blood and his stomach irrigated several times, he stopped bleeding and his vital signs stabilized. His gastrointestinal X-rays were negative and he went home in a spica cast. Two weeks later he reappeared complaining of upper-abdominal pain. That night in the hospital he again vomited an alarming amount of fresh blood and had melena. Finally, the senior resident thought of hematemesis.

A selective hepatic angiogram demon-



Figure 1. The greater contour of the stomach is indented by a splenic hematoma.

strated a puddle of contrast material leaking out from a branch of the hepatic artery. (Fig. 2) At operation, he was found to have a deep laceration of the liver through the bed of the gallbladder, exactly between the right and left lobes. There was considerable reaction about the liver. The gallbladder was removed and a few hepatic bleeding points in the depths of the wound were ligated. He had an uneventful postoperative course.

JOHN G. RAFFENSPERGER, M.D., is head of the Division of General Surgery at Children's Memorial Hospital and associate professor of surgery at Northwestern University. Dr. Raffensperger is the author of *THE ACUTE ABDOMEN IN INFANCY AND CHILDHOOD* and *PEDIATRIC SURGERY FOR NURSES*.



Abdominal trauma



Figure 2. Note the extravasated contrast material from the hepatic arteriogram. This patient had hemato-bilia which appeared two weeks after abdominal injury.

Always suspect hemato-bilia when there has been abdominal trauma and the patient develops biliary-colic type pain, accompanied by gastrointestinal bleeding. The typical lesion is a cavity in the right lobe filled with blood, bile and necrotic liver. Selective hepatic angiography is essential to establish the diagnosis and to plan therapy.

The gastrointestinal tract, duodenum

Duodenal perforations into the retroperitoneal space present a special problem. The child has abdominal pain radiating to his back, with vomiting and fever. He is not likely to have the tenderness and rigidity usually associated with intestinal perforations. Serial observations

of the vital signs and of the abdomen should arouse your suspicion. Roentgenograms may show retroperitoneal air around the kidney and right crux of the diaphragm. The right psoas shadow will be obliterated or outlined by air. Contrast studies of the stomach and duodenum may be helpful.

Small bowel

The jejunum or terminal ileum may be injured where they cross the vertebrae. In either location, a bowel loop is tethered and easily crushed between the anterior abdominal wall and the vertebra. There may be only a small perforation, with mucosa pouting through the hole, or there may be a more extensive tear with an associated laceration of the mesentery. In either case, the child immediately complains of severe abdominal pain and on his arrival at the hospital he is found to have diffuse tenderness and often board-like abdominal rigidity. An X-ray is hardly necessary to determine the need for a laparotomy, but an upright roentgenogram may show free air under the diaphragm. If there is delay in making a diagnosis, the resulting peritonitis results in rapid fluid shifts, with plasma loss and shock.

Intramural hematoma of the duodenum

The highest incidence of intramural hematoma of the duodenum is in children under 12-years-of-age. The relative fixation of the duodenum, its abundant blood supply, and its close relationship to the bony structures of the spine make it an ideal target when trauma is inflicted against a relaxed abdominal wall. It is said that drunks and children are more frequently injured in this manner because of their ungaurded abdominal walls.

Classically, there is fleeting abdominal pain and discomfort after the initial trauma; several hours or days later the child begins to vomit copious amounts of bilious material, indicating the obstructive nature of the process. An upright roentgenogram may show an air fluid level in the stomach and proximal duodenum resembling a double bubble sign. This history should prompt an upper gastrointestinal examination which will show the mucosal folds to be stretched and compressed by the intramural hematoma, the classic "coiled spring" appearance. Trickle of barium may get by into the normal jejunum.

Opinion is divided between managing these lesions with long-term gastric suction while the hematoma reabsorbs, or operative by drainage and decompression. In one child the obstruction resolved, in all the others an operation was necessary.

Pancreatitis

Pancreatitis classically results when a boy's bicycle strikes an object and he is thrown against the handlebars. An elevation of the serum amylase may be diagnostic for either pancreatitis or a perforation of the upper bowel.

When there is only minimal upper abdominal tenderness and a mild elevation of the amylase one is justified in treating the child with nasogastric suction, intravenous fluids and atropine.

If the symptoms promptly subside and do not recur, operation is not indicated; the child should be watched for the development of a pseudocyst. If, however, there is real abdominal tenderness, an operation is indicated. Roentgenograms may show a "sentinel loop" of dilated bowel, or the gastric gas bubble may be pushed forward by pancreatic fluid and edema. Drainage of the lesser omentum with a sump tube is indicated for a contused pancreas. If the pancreas is lacerated or transected, its distal portion may be resected, or drained into an isolated loop of bowel.

A pseudocyst following trauma will typically be located in the epigastrium; on lateral roentgenograms the stomach is displaced forward. Anastomosis of the cyst to an isolated Roux-en-Y loop is the preferred treatment.

Large bowel

The colon is the least likely part of the gastrointestinal tract to be injured by blunt trauma. During the past five years, we have seen 12 small-bowel perforations and one injury of the cecum. This occurred in a boy who was caught between the bumpers of two automobiles. He arrived at the hospital four hours later, more dead than alive. His abdomen was filled with feces, and there was a huge tear in the cecum. He just barely survived after the lesion was exteriorized and he was treated with large doses of antibiotics, blood and plasma.

Trauma to the genitourinary tract

If an injured child does not spontaneously void soon after his admission to the hospital, insert a catheter for a urine sample. If he is in

shock or if a severe injury is suspected, the catheter should be left in place to check accurately his urinary output. The catheter is never removed if there is any sign of bladder or urethral injury. Blood mixed with urine is evidence of injury to the kidney or bladder, while the spontaneous appearance of gross blood at the meatus is diagnostic for urethral injury.

Automobile accidents, falls, and penetrating injuries account for most renal injuries. In most instances, the child complains of poorly localized abdominal pain, but, on examination, tenderness is limited to the flank. Hematuria is the most common finding which leads to further study. Microscopic hematuria is commonly found in injured children and usually indicates a renal contusion, since the intravenous pyelogram is normal. More severe and persistent bleeding is associated with renal lacerations.

An infusion pyelogram is required to provide the type of detail necessary to make decisions concerning further study and therapy. We are concerned with the status of the opposite kidney, with preexistent renal malformations, and with those abnormalities caused by injury. An intrarenal hematoma will enlarge a kidney and distort the collection system, while perirenal collections of blood or urine may change the axis or the position of the kidney. Extravasated contrast material outlining the surface of the kidney indicates a perforation of the renal pelvis or an extension of a laceration from the calyceal system through the renal parenchyma. Roentgenograms taken in the oblique and prone positions are sometimes necessary to demonstrate these findings.

If the child's hematuria shows progressive clearing during several hours of observation, and if the intravenous pyelogram demonstrates minimal to moderate distortion, treatment should be continued—bed rest, with catheter drainage and antibiotic coverage. This conservative treatment for renal injuries has been eminently successful. Complete recovery is the rule, even when there is evidence for urinary extravasation and considerable bleeding.

On the other hand, if there is continued hematuria, a falling hematocrit, and signs of renal disruption on the intravenous pyelogram, a selective abdominal aortogram may be performed to further delineate the extent of renal damage. Renal arteriography is indicated if an operation is contemplated to control hemorrhage or extravasation of urine. If there are other abdominal injuries, indicating the need for surgery,

Abdominal trauma

time should not be wasted obtaining an arteriogram.

The child who insists on stopping the family car to "go potty" every hundred miles just wants to avoid a ruptured bladder! Minimal trauma to the full bladder results in rupture of the dome into the peritoneal cavity. There may be only mild lower abdominal tenderness and distortion. The child will either have hematuria, or will pass no urine at all.

A cystogram will make the diagnosis and should always be done on a child with a fractured pelvis. Treatment is by surgical repair and suprapubic cystotomy drainage.

Plan for management

The initial therapy for a child with abdominal trauma consists of securing two "foolproof" upper extremity intravenous sites. One of them should be a catheter in the superior vena cava or right atrium to monitor central venous pressure. Initially, enough lactated Ringer's solution or plasma is given in sufficient quantities to restore peripheral circulation and to bring the central venous pressure (C.V.P.) up to normal. Care should be taken not to overload the small child. Blood or plasma should only be given in increments of 10 ml per pound of body weight, rather than in "500 ml units." Reevaluate the vital signs including the C.V.P. after each increment transfused.

Prior to operation review the child's condition and make certain of the following points.

- 1) Two satisfactory *upper extremity* intravenous sites.
- 2) Have six 500 cc units of blood available for the operating room.
- 3) Have a functioning nasogastric tube and urethral catheter.
- 4) Premedicate only with atropine, use no narcotics or other sedatives.
- 5) Use endotracheal anesthesia.
- 6) Have a full set of surgical instruments including vascular clamps; and two functioning suction tubes. When preparing and draping the child, include the chest. If there is a liver laceration it may be necessary to extend the incision into the right hemithorax.

The surgeon should stand by the child during induction of anesthesia. If the blood volume has not been completely restored with transfusions, the release of vasoconstriction by anes-

thesia will cause a precipitous drop in blood pressure. Also as the abdomen is opened, the tamponading effect of the abdominal wall is lost and further hemorrhage and shock may result in an avoidable death on the operating table.

Most surgeons prefer a vertical midline incision because this gives access to all intra-abdominal organs and is easily extended into either thoracic cavity. On opening the abdomen, all blood or fluid is removed by suction and the abdomen rapidly explored. A normal-sized spleen is easily removed, but make sure that all splenic fragments are found to avoid splenosis. Superficial liver lacerations require only drainage since they usually stop bleeding spontaneously. More extensive lacerations, particularly of the right lobe, require extension of the incision into the right thorax to gain control of the hepatic veins as well as the porta hepatis. Lobectomy is sometimes necessary to control hemorrhage and to remove necrotic liver material.

Small bowel perforations are easily dealt with by simple closure or resection. Colon lacerations from blunt trauma result in severe fecal soilage and devitalized bowel. These are best treated by exteriorization or repair and proximal colostomy decompression.

Complete mobilization and inspection of the duodenum is indicated if there is any edema or hemorrhage in the central retroperitoneal area. A contused pancreas merely requires sump tube drainage but tears or lacerations require pancreatic resection or drainage by a Roux-loop.

Exploration of retroperitoneal hematomas about the kidneys, when necessary, is accomplished by first exposing the aorta and superior vena cava, and controlling the renal artery and vein. It is then possible to safely open these hematomas, debride devitalize tissue, and salvage all viable kidney tissue. All injured solid viscera are drained using sump and soft rubber tubes. Intra-abdominal recesses are drained in septic cases.

The abdomen is closed in one layer with double medium strength (30) stainless steel wire. The skin is left open in colon and pancreatic injuries.

Postoperatively, injured children are observed in the intensive care unit until they are sufficiently stable to be transferred to a ward. ◀

(References on page 423)

BY ROBERT R. HARTMAN, M.D./JACKSONVILLE

Maternal death study

Case report No. 2

The second in a series of case reports

ONE OF THE FUNCTIONS of the ISMS Committee on Maternal Welfare is to analyze the causes of deaths in Illinois mothers and to determine, if possible, what alterations in management and treatment could have prevented any of these deaths. Each month a case will be presented and discussed in an attempt to promote more modern methods of obstetrical management.

Case Report:

This 15-year-old white nullipara was admitted to the hospital early in her labor with the cervix 50% effaced, the presenting part floating, and the clinical diagnosis, confirmed by X-ray, of transverse lie. The membranes ruptured and the patient went into good labor having contractions every 3-5 minutes. After two hours the cervix was perhaps 80% effaced and 3 cm. dilated. A foot could be felt; the transverse lie persisted and it was decided to do a Cesarean section. The patient was markedly apprehensive when admitted to surgery.

Your committee did not have available to it the type of anesthetic used except that it was inhalation anesthesia administered by a nurse anesthetist. Immediately after delivery of the baby it was noted that the patient was markedly cyanotic and the anesthetist was experiencing difficulty. Aortic pulsation being absent, cardiac resuscitation was started, an air-way inserted, and cardiac rhythm and voluntary respiration were restored. Following completion of the procedure, the patient was transferred to the intensive care unit where her condition deteriorated and on the third postoperative day she expired with evi-

dence of decerebrate rigidity and no regaining of consciousness.

Anatomic diagnoses included cardiac arrest, no abnormalities of the cardiovascular system, pulmonary edema, chronic bronchitis with pneumonia, and cerebral edema with uncinata notching.

Your committee felt obligated to assume this as a direct obstetrical death due to anesthesia. Cardiac arrest on the operating table is almost always due to anoxia subsequent to a poor airway. In an effort not to depress the baby, post-operative medication of the obstetrical patient is often neglected. However, the use of ataractic drugs in moderate amounts is usually not followed by fetal depression and may do much to relieve patient anxiety. Further, it is felt by your committee that the maintenance of an adequate airway is essential for any patient undergoing Cesarean section under general anesthesia. A widely used technique gaining more and more acceptance is the use of small amounts of pentothal followed by muscle paralyzing drugs such as anectine with subsequent intubation and maintenance of airway by bag breathing of a high

Maternal death report

concentration of oxygen and nitrous oxide.¹ It is felt that all cases of cardiac arrest occurring with anesthesia carry at least a measure of preventability.

Reference

1. Dripps, Eckerhoff and Vandam: INTRODUCTION TO ANESTHESIA. 3rd Edition, W. B. Saunders—1968.

ROBERT R. HARTMAN, M.D., is an obstetrician-gynecologist in Jacksonville and chairman of the ISMS Committee on Maternal Welfare. He received his M.D. degree from Northwestern University Medical School.



Doctor your cooperation is needed . . .

In the referral of patients with melanomas and sarcomas of soft tissue and bone

The cooperation of physicians is requested in the referral of patients with melanomas and sarcomas of soft tissue and bone for studies being conducted by the National Cancer Institute's Surgery Branch at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Needed are patients with primary tumors and those with limited metastases which are amenable to primary surgical treatment. Selected patients will be admitted to combined surgery, chemotherapy, and immunotherapy protocols.

Patients treated will receive adjuvant therapy according to criteria based on tumor anatomic location and histologic type. Immunologic studies will be performed preoperatively and at intervals postoperatively to monitor the effects of adjuvant therapy and provide sensitive means of follow-up for earlier detection of recurrent tumor.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

In the referral of patients with cancer of the oral cavity, pharynx, larynx or sinuses

The cooperation of physicians is requested in the referral of patients with cancer of the oral cavity, pharynx, larynx, or paranasal sinuses for studies being conducted by the National Cancer Institute's Surgery Branch at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Patients selected for admission and treatment will be included in an adjuvant-therapy protocol where the treatment modalities of surgery, irradiation, and chemotherapy will be combined in such a manner as to determine the feasibility of such a therapeutic approach and its potential

for decreasing the incidence of local recurrence and metastases.

Post-treatment studies are planned which will include cooperative follow-up between the referring physician and the National Cancer Institute.

Physicians interested in having their patients considered for admission to these studies may write or telephone:

Alfred S. Ketcham, M.D.
Clinical Center, Room 10-N-116
National Institutes of Health
Bethesda, Maryland 20014
Telephone: 301-496-4164

Report of a case

Retroperitoneal and gluteal cystic lymphangioma

A RETROPERITONEAL CYSTIC lymphangioma is an uncommon growth, and a retroperitoneal lesion extending into the gluteal area is exceedingly rare. (Fig. 1) Our review of the literature has not disclosed a similar case report.

In 1893, Sarway¹ first reported the excision and cure of a retroperitoneal cystic lymphangioma in an 11-year-old female. Our review of the literature disclosed reports of 37 other cases.* Our case then is the thirty-eighth and the only one with a gluteal extension.

Case Report

A seven-year-old, white female with abdominal pain was first seen in the Emergency Room of Evanston Hospital on June 23, 1968. At age 17 months, and again at age 4 years, she had been operated upon elsewhere for a diffuse tumor of the right buttock. This had recurred. The family history was non-contributory.

Her presenting complaint was that of 22 hours of constant pain following minor blunt lower abdominal trauma. It was greatest in the right lower quadrant. She complained of nausea and anorexia and had vomited once.

Examination disclosed an acutely ill child lying quietly with her knees flexed. Her oral temperature was 102 degrees, the heart rate was 136 per minute and the respiratory rate was 32 per minute. There was marked tenderness, guarding and rebound tenderness in the right lower quadrant where a well delineated mass was palpable. Tenderness to a lesser degree was noted elsewhere in the abdomen. Bowel sounds were present, but hypoactive. Her leukocyte count was 18,100 per cubic millimeter of blood with 89% segmented

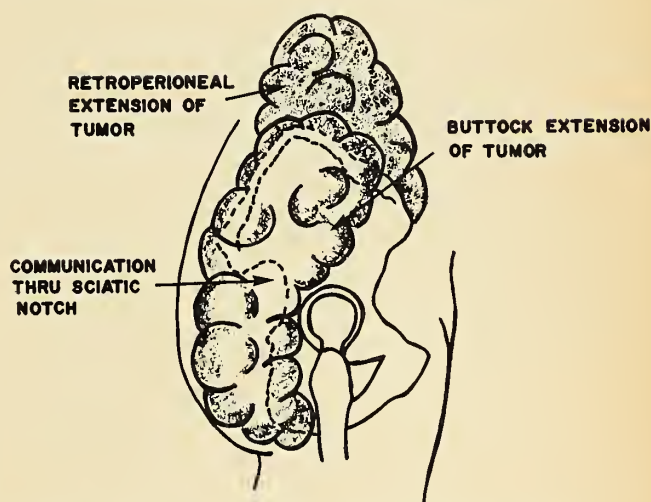


Figure 1. Drawing showing retroperitoneal and gluteal cystic lymphangioma with communication through the sciatic notch.

*1893 Sarway 1 case; 1903 Sick 1; 1913 Gaudier and Gorse 1; 1925 Westman 1; 1931 Buchaneddin 1; 1931 McFadden 1; 1934 Kyetschmere and Hibbs 1; 1939 Gerster 1; 1939 Ingraham and Nelson 1; 1942 Lee 1; 1947 Nichols 1; 1950 Beahrs et al 2; 1951 Lingenfelter and Howard 1; 1955 Hsu and Ming 1; 1956 Simon 2; 1957 Harrow 1; 1958 Morse et al 1; 1959 Norfleet et al 1; 1959 Rauch 2; 1959 Delgado Perraera et al 1; 1960 Barrett 1; 1961 Fuduka et al 1; 1961 Larson et al 2; 1962 Schlicht 1; 1962 DeSanctis et al 1; 1963 Bottini 1; 1963 Thrupp 1; 1964 Gordon 1; 1964 Fouty 1; 1964 Flateau et al 1; 1964 Oster et al 1; 1965 Hoffman 1; 1966 Henzel 1 case.

Lymphangioma



Figure 2. Photograph showing diffusely enlarged right buttock.

cells. A urinalysis disclosed six to ten white blood cells per high power field and a trace of albumin.

At operation, there was a large quantity of "free" odorless, slightly cloudy yellow fluid, and a large ruptured cystic mass in the right lower retroperitoneal space. Fluid from the cyst had a urea nitrogen value of 7 milligrams per 100 milliliters of blood and a culture subsequently was reported as being sterile. On reflecting the right colon medially, the cystic mass was found to extend from the right anterior-superior iliac spine to the midline and from the lower pole of the right kidney distally into the true pelvis. It was multiloculated, well circumscribed and contained free floating solid material. Exploration of the peritoneal cavity ruled out intraperitoneal extension. Two uninvolved, normal sized kidneys were palpable in their usual position. A 30 minute operative intravenous pyelogram film confirmed their location.

The urinary bladder, ovaries, fallopian tubes and uterus appeared normal and could be separated from the cyst. Frozen section examination of the cyst lining showed a benign endothelium with a marked inflammatory reaction. A catheter inserted into the urinary bladder drained clear urine and irrigation fluid did not reflux into the cyst. A vaginal examination was normal.

The multiloculated cyst was excised. It was carefully dissected free of the adherent right ureter. In the pelvis it assumed a funnel shape with its apex at the sciatic notch where it com-

municated with the mass in the right buttock. Her postoperative recovery was uneventful and she was discharged on June 30, 1968.

The patient was readmitted November 24, 1968 for reexcision of the buttock growth. (Fig. 2) Examination of the abdomen was unremarkable. The buttock was diffusely enlarged, twice normal size, firm and smooth. There was a well-healed scar in the gluteal crease.

At operation a transverse incision was made two inches cephalad to the anus. Skin flaps were developed to above the iliac crest and down to the gluteal crease. The gluteus maximus was divided in the course of its direction and a large, multilocular cyst was present below it. This extended beneath the sacral vertebrae to the opposite side, cephalad to above the iliac crest and distally to beyond the gluteal crease where it intermingled with dense fibrous connective tissue. The cyst enveloped the sciatic nerve at its exit through the sciatic notch. As much of the lesion was removed as was technically possible. She had an essentially uneventful recovery and was discharged on December 5, 1968. When last examined in February 1970, there was no evidence of recurrence of the lymphangioma.

Pathology

The retroperitoneal specimen of June 1968, was a multiloculated cyst measuring 8 x 6 x 3 cm. Microscopic examination disclosed numerous, large vascular spaces lined by flat endothelium. (Fig. 3) The wall contained smooth muscle, but

no elastic tissue. The stroma consisted of fat and loose connective tissue. There was a marked, acute inflammatory reaction.

The multiloculated right buttock cyst excised in November, 1968 measured 11 x 5 x 2 cm. The microscopic findings were identical to those described above.

Microscopic sections were obtained from her surgical procedures done elsewhere in September 1962, and in June 1965. A multiloculated cystic lesion was removed in September, 1962. The microscopic findings were identical to those described above. In June 1965, the microscopic appearance was that of lobulated fatty tissue.

Etiology and Embryology

Embryologically, lymph vessels are believed to develop either as independent formations which secondarily acquire venous connections² or as endothelial outgrowth of veins.³

Arey² has described five regional primitive lymphatic sacs: the paired jugular sacs lateral to the internal jugular veins, an unpaired retroperitoneal sac at the root of the mesentery and the paired posterior sacs adjacent to the sciatic veins. Normally these sacs evolve into chains of lymph nodes to the head, neck and arm, to the mesentery, and to the hip, back and leg, respectively. Lymphangiomas develop at the sites of these primitive lymph sacs.

There are three characteristics of all lymphangiomas. The first is their isolation from normal tissues. Goetsch⁴ described them as a sequestration of a portion of the primitive lymphatic sac which fails to establish communications with normal lymphatic channels.

The second is that of arrested differentiation and development of this portion of the embryonal lymphatic system. These congenital mal-



Figure 3. Slide showing large cystic spaces lined by flat endothelium. The stroma consists of fat and connective tissue with a marked, acute inflammatory reaction (hematoxylin and eosin).

formations are classified by Jones⁵ as hamartomas, which by definition are not true neoplasms, but rather the faulty embryonal development of cells natural to the part.

The third is that of continued growth in the manner characteristic of the primitive lymphatic system.

Other theories⁶ relate them to such possible factors as irritation, inflammation, trauma, fibrosis, lymph node degeneration and disturbances of the endothelial secretory function.

Classification

As a group intra-abdominal cysts, including retroperitoneal lesions, are uncommon. Lahey and Eckerson⁷ divided them as: (a) enteric; (b) urogenital; (c) dermoid-teratoid; (d) parasitic-inflammatory; (e) traumatic hemorrhagic; and (f) lymphangiomatous. The intra-abdominal

MIGUEL A. OVIEDO, M.D., (right) is a resident in general surgery at Northwestern University Medical School and Evanston Hospital. He received his M.D. degree from the University of Buenos Aires, Argentina. He was recently named the recipient of the 1972-1973 American Cancer Society Training Fellowship at Evanston Hospital.

NORMAN LARSON, M.D., F.A.C.S., (center) is assistant professor of surgery at Northwestern University and on the attending staff at Evanston Hospital. He received his M.D. degree from Northwestern University.

GERARD PARENT, M.D., (far right) is an intern at the University of Chicago Hospitals and Clinics. He received his M.D. degree from Johns Hopkins University School of Medicine.



Lymphangioma

lymphangioma is further classified by these authors as a neoplastic cyst. It is a congenital, benign, slowly growing lesion with limited connections to normal lymphatics.

Beahrs and associates,⁸ in reviewing all Mayo Clinic intra-abdominal cystic tumors from 1911 to 1947, found nine of 174 were chylous retroperitoneal or mesenteric lymphangiomas. Parsons,⁹ in 1936, reported only 10 cystic lymphangiomas among 500 mesenteric cysts, and Harrow¹⁰ found 14 cysts of retroperitoneal lymphatic origin among 600 mesenteric cysts.

The grouping of intra-abdominal lymphangiomas by their location in the mesentery, omentum or retroperitoneal space is not completely accurate because the mesentery and omentum are extensions of the retroperitoneal space, and because large cystic lesions can overlap into adjacent areas. Because of this the term "retroperitoneal" has been applied by some authors to all three areas. There are, however, some advantages in discussing these cysts by location. The omental and mesenteric cysts are more common and they are usually unilocular or dumbbell-shaped. They are often symptomatic. Retroperitoneal lymphangiomas are frequently multicystic and are usually asymptomatic.

Histological Classification

Wegner¹¹ has divided lymphangiomas into three types: (a) the simple type which is uncommon (intra-abdominal lesions do not occur); (b) the cavernous type which is the most common overall, and seen infrequently as an intra-abdominal lesion. (Two cases of malignancy have been reported.¹²); and (c) the cystic type which is the common intra-abdominal and retroperitoneal lymphangioma. Ackerman¹³ has stated the cystic lymphangioma is always benign. On occasion an admixture of these three types can be found in a single lesion.

Harrow's¹⁰ criteria for diagnosis of the cystic lymphangioma includes the following: (a) an endothelial or absent lining; (b) small lymphatic spaces; (c) fairly abundant lymphoid tissue in the wall; and (d) lipid containing foam cells.

Intra-abdominal (and retroperitoneal) lymphangiomas are similar histologically to the childhood cervical cystic hygromas. The contents of the cyst can be serous fluid with protein precipitates or chylous fluid in those cysts located in the upper small bowel mesentery. The endothelial lining can be flattened or destroyed by the

persistent intracystic pressure. The lymphoid tissue may appear as a diffuse collection of lymphocytes or in configurations resembling lymph nodes. Connective tissue, fat, blood vessels and nerves are also present. Edema, round cell infiltration and fibrosis are common, especially in the large retroperitoneal lymphangiomas. The growths are not encapsulated.

Diagnosis

There is no sex or age predilection for patients with intra-abdominal lymphangiomas. They are rarely diagnosed preoperatively. Thrupp¹⁴ states 57.2% of cases had an asymptomatic abdominal mass, 23.8% had complications of infection or hemorrhage and 19% were incidental postmortem or operative findings.

Patients with symptomatic retroperitoneal growths present often with a slowly growing abdominal mass, dull flank or back pain and a "dragging" sensation.

Those with omental and mesenteric lymphangiomas are seen frequently with partial or intermittent intestinal obstruction, twisting of the tumor pedicle, traumatic rupture of the cyst and hemorrhage.

Roentgenographic studies may demonstrate displacement of viscera on the intravenous pyelogram or gastrointestinal series. There are, however, no specific roentgenological diagnostic signs.

Treatment

Whenever possible intra-abdominal lymphangiomas should be completely excised. This can be done more often in the unilocular and dumbbell-shaped mesenteric and omental cysts than in the multicystic retroperitoneal lesions.

When the relationship to vital structures excludes complete removal, as much of the lining should be excised as possible. Swabbing the remaining surface with sclerosing solutions has been advocated by some authors.¹⁵

Summary

Because of the benign nature of the cystic lesions, marsupialization is an acceptable alternative to complete excision. Decompression to the skin, however, is accompanied frequently by infection. Authors^{12,16} have reported successful drainage into an adjacent loop of the gastrointestinal tract and even into the peritoneal cavity.

A rare case of a retroperitoneal cystic lymphangioma with extension into the gluteal area has been presented. ◀

References

1. Sarway, O.: "Ein Fall von Retroperitonealer Chylus cyste bei einem II jährigen Mädchen Extirpation, Heilung," *Centrabl Gynak*, 22:407, 1898.
2. Arey, L. B.: *DEVELOPMENTAL ANATOMY*. Ed. 5, Philadelphia and London, W. B. Saunders Company, 1948, pp. 358-361.
3. Sabin, F. R., cited by Rauch, R. F.: "Retroperitoneal Lymphangioma," *Arch. Surg.*, 78:45, 1959.
4. Goetsch, E.: "Hygroma Colli Cysticum and Hygroma Axillare; Pathologic and Clinical Study and Report of 12 Cases," *Arch. Surg.*, 36:394-479, March, 1938.
5. Jones, J. H.: *Proc. of the Royal Soc. of Med.*, 59:673, 1966.
6. Barnett, L. A.: "Retroperitoneal Cystic Lymphangioma," *J.A.M.A.*, 173:1111, 1960.
7. Lahey, F. H. and Eckerson, E. B.: "Retroperitoneal Cysts," *Ann. Surg.*, 100:231, 1934.
8. Beahrs, O. H., Judd, E. S. and Dockerty, M. B.: "Chylous Cysts of the Abdomen," *Surg. Clin. N.A.*, 30:1073, 1950.
9. Parsons, E. O.: "True Proliferating Cystic Lymphangiomas of the Mesentery," *Ann. Surg.*, 103:595, April, 1936.
10. Harrow, B. R.: "Retroperitoneal Lymphatic Cyst (Cystic Lymphangioma)," *J. Urol.*, 77:82, 1957.
11. Wegner, G.: "Veber Lymphangiome," *Arch. Klin. Chir.* 20:641, 1877.
12. Hentzel, J. H., Pories, W. Y., Burget, D. E. and Smith, J. L.: "Intra-abdominal Lymphangiomas," *Arch. Surg.*, 93:304, 1966.
13. Ackerman, L. V.: "Tumors of the Retroperitoneum, Mesentery and Peritoneum," *ATLAS OF TUMOR PATHOLOGY*, Washington, D.C., United States Armed Forces Institute of Pathology, 1954, pp. 87-89.
14. Thrupp, M. H.: "Retroperitoneal Cystic Lymphangioma," *Med. J. Aust.*, 1:617, 1963.
15. Larson, D. L., Myhre, B. A., Schmidt, E. R. and Jaeschke, W. H.: "Lymphangioma in Unusual Sites: Spleen, Mesentery, Retroperitoneum, Mediastinum and the Greater Omentum," *Wis. Med. J.*, 60:279, 1961.
16. Hoffman, E.: "Multicystic Retroperitoneal Lymphangiomas Presenting as an Indirect Inguinal Hernia in a Newborn," *Amer. Surg.*, 31:525, 1965.

Hazards in living

Millions of young to middle-aged Americans are now engaged in seeking their livelihood in the midst of formidable hazards to human life and health created by technological research and its practical applications, while the population of the country, generally, especially in its crowded cities, is being subjected to the inadequately explored effects of the processes, products, and wastes of an industrial activity which has developed the power to alter the physical, biological, economic, and social structure of the nation. This technological outburst, with the possible exception of the disastrous two world wars of our time, has furnished us with the most remarkable mass phenomena in the history of mankind. One might suppose that ordinary prudence would have dictated that the potential effects of impingement of technology upon the general population of this nation (and others), and especially upon those employed in production, at least with respect to its effects upon mortality, morbidity, disability and the general health of these, the most directly involved people, would have been investigated thoroughly, long since, and brought under adequate control by the medical and hygienic professions, institutions of research and training, and governmental agencies of the country. But such has not been the case, and, while it might be desirable, in some respects, to pay attention to why this is true, we might better, at this time, acknowledge the general preoccupation of the professional wardens of the nation's health with other seemingly more important matters than those of the somewhat obscure threats of life, health and well-being visited upon our people by the apparently beneficent progress of technology. (Robert A. Kehoe: *Environmental and Occupational Health—Their Professional Representation and Relationship*, *Jl. of Occupational Medicine*, 14:2, Feb., 1972, pgs. 115-118.)

Prenatal hormones and human behavior

THERE ARE SIX FACTORS of sexual differentiation:

Table I
Factors in Sexual Differentiation

1. Sex chromosomes
2. Gonadal structure
3. Hormones and phenotypic morphogenesis
 - a) fetal
 - b) pubertal
4. Hormones and nervous system
 - a) fetal
 - b) pubertal
5. Sex of assignment and rearing
6. Gender identity

The study of hermaphrodites, in which incongruities among these factors occur, uniquely allows one to differentiate among these factors and to examine their influence on psychosexual behavior—in particular the influence of fetal hormones on the nervous system, in relation to postnatal events according to sex of assignment and rearing.

Animal experimentalists have demonstrated that fetal androgens have not only an irreversible effect on the differentiation of mammalian external genitalia, but also on parts of the nervous system mediating certain aspects of postnatal sexual behavior (Harris, 1964; Whalen, longitudinal study of childhood behavior, Goy 1967). Two experiments epitomize the main points of relevance. In the Oregon Regional Primate Center, pregnant Rhesus monkeys were injected with testosterone and some of them gave birth to genetic female offspring with masculinized external sexual organs, including a penis and an empty scrotum. The internal organs were not affected and were normally female. In a longitudinal study of childhood behavior, Goy and his colleagues in 1970, found that these hermaphroditic female monkeys gained more masculine scores than normal females on the criteria of rough and tumble play, play initiation, social threat, masturbation and mounting. At puberty, they menstruated cyclically. Their postpubertal behavior is still under study.

The converse of the androgenized female is the unandrogenized male. Genetic male rats can be produced with completely female external genitalia if hormonally castrated at the critical time of antenatal differentiation. Neumann and his colleagues, in 1966 in West Berlin, found

Condensed version of a paper given on December 9, 1970 by Dr. Ehrhardt at the Barren Foundation Seminar "Psychological or Emotional Aspects of Infertility," Wesley Memorial Hospital, Chicago, Illinois.

that these animals simulate a normal female in mating behavior after removal of their testes and substitution therapy with estrogen and progesterone. Doerner, in 1967 in East Berlin, obtained partial analogous behavior results even when rats were surgically castrated neonatally and after the penis had formed.

The analogue of the monkey experiments is found in two clinical syndromes: One is the syndrome of progestin-induced hermaphroditism, in which a female child's sex organs are masculinized and ambiguous at birth as an untoward side-effect of synthetic progestins administered earlier to her pregnant mother to prevent miscarriage (Ehrhardt and Money, 1967); the other is the female adrenogenital syndrome, in which masculinized, ambiguous external genitalia are the end result of a genetically determined defect of adrenocortical function, beginning in fetal life (Ehrhardt, Epstein and Money, 1968; Ehrhardt, Evers and Money, 1968). Since cortisone correctly regulated adrenal function after birth in the adrenogenital syndrome, and since progestin-induced hermaphroditism is self-correcting after birth, one has the opportunity in both syndromes to study the effect of fetal masculinization on the brain and subsequently on behavior.

Girls with Turner's syndrome illustrate the principle that feminine differentiation ensues in the absence of fetal gonadal androgens—somewhat a human parallel to the feminized rats.

The study of possible prenatal hormonal influences on behavior in human females was carried out at the Johns Hopkins Hospital in the Psychohormonal Research Unit.

We studied 10 girls with progestin-induced hermaphroditism, 15 girls with the early-treated adrenogenital syndrome, and 15 girls with Turner's syndrome. Cortisone treatment for the adrenogenital syndrome has only been available since 1950. The progestinic drugs with masculinizing side-effects were also mainly prescribed in the 50s. Consequently, the age of the patients ranged, at the time of the study, from early

childhood to teen-age, with most of the children falling into middle childhood and early teen-age. The youngest girl was four and the oldest was 16 years of age. Girls with Turner's syndrome covered the same age range.

The patients were matched with normal controls selected from Baltimore public schools on a one-to-one basis according to age, race, socioeconomic status of the family and IQ. Thus, all together, we studied 80 children and their mothers with several sex-role preference tests and semi-structured interviews.

Table II
Sexual Activities in Childhood

	PI vs C	AGS vs C	TS vs C
1. Attention to genital morphology	•	•	•
2. Masturbation	•	•	•
3. Shared genital inspection and play	•	•	•
4. Shared copulation play	•	•	•
Legend:			
PI=Progestin-induced hermaphroditism (N=10)			
AGS=Adrenogenital syndrome (N=15)			
TS=Turner's syndrome (N=15)			
C=Matched controls			
•=No significant difference			

From the summarized findings in the tables, it appears as if certain aspects of sex-related behavior may be modified by fetal androgens in girls with progestin-induced hermaphroditism and girls with the adrenogenital syndrome. Females with a history of high levels of fetal androgens differed from their controls in respect to a comparatively low interest in childhood rehearsal in fantasy and play of pregnancy, childbirth and maternal caretaking. Maternalism was subservient to their predominant goal of career and educational interests.

They also had a higher level of physical energy expenditure, frequently preferred boys to girls as playmates, were typically not interested in feminine clothing, hairdo and jewelry, and chose cars, trucks, guns and other boys' toys more often than dolls. Significantly, more girls in both patient groups than in the control groups



ANKE A. EHRHARDT, Ph.D., is research assistant professor in pediatrics and psychology in the respective departments at the State University of New York at Buffalo. She received her Ph.D. in psychology from the University of Düsseldorf, Germany. Dr. Ehrhardt is the author of numerous articles on the effects of hormones on behavior.

JOHN MONEY, Ph.D., is a psychologist and associate professor of medical psychology and pediatrics at the Johns Hopkins University and Hospital. He received his Doctor of Philosophy from Harvard University.



Prenatal hormones

identified themselves and were identified by their mothers and peers as tomboys (Ehrhardt, 1971).

Table III

Romance, Marriage and Maternalism

	PI vs C	AGS vs C	TS vs C
5. Homosexual fantasies	•	•	•
6. Heterosexual romanticism in play and daydreams during childhood	•	•	•
7. Adolescent daydreams and relationships with boys (age 13-16)	•	•	•
8. Wedding and marriage anticipation in play and daydreams	•	*	•
9. Priority of marriage vs career	*	*	•
10. Daydreams and fantasies of pregnancy and motherhood	•	*	•
11. Toy preference (dolls vs cars, guns, etc.)	*	*	•
12. Interest in infant care	•	***	•

Legend:
PI=Progestin-induced hermaphroditism (N=10)
AGS=Adrenogenital syndrome (N=15)
TS=Turner's syndrome (N=15)
C=Matched controls
•=No significant difference
*=p < .05
***=p < .001

Girls with Turner's syndrome were in no aspect less feminine than their matched controls. Any difference that occurred was in the direction of greater femininity which shows that a completely feminine gender identity can ensue in the absence of any of the individual's own gonadal hormones, even with a missing second sex chromosome (Ehrhardt, Greenberg and Money, 1970).

The data on girls with a history of fetal masculinization suggest that androgenic hormones in utero may influence postnatal female gender-identity differentiation. If so, the influence is limited in scope and does not induce anything approaching a sexual identity reversal. As stated in the beginning, human psychosexual differentiation depends on the interaction of several factors (Table I) in which social environmental experiences play a major, if not the most important role.

The importance of postnatal, social-developmental determinants on sexual differentiation is demonstrated when two patients with the female adrenogenital syndrome, one raised as a girl and one as a boy, are compared. In one such matched pair, both patients were exposed to ambivalence and uncertainty regarding their sex of rearing in their social environments. Both of them wanted to be reassigned to the opposite sex at age 11 (Money, 1968 a.). By contrast, congruence between psychosexual identity and sex of assignment is found in the majority of hermaphrodites, even if reared in contrast to their genetic, gonadal and phenotypic sex, provided uncertainty as to the appropriateness of the sex of rearing is minimal or, better still, totally absent (Money, 1968 b.).

Table IV

Clothing, Energy and Tomboyism

	PI vs C	AGS vs C	TS vs C
CLOTHING PREFERENCE AND COSMETIC INTERESTS			
13. Clothing preference (slacks vs dresses)	*	**	•
14. Jewelry, perfume and stylish hairdos	•	•	*
PHYSICAL ENERGY EXPENDITURE LEVEL			
15. Athletic interests and skills	*	(*)	*
16. Preference of male vs female playmates	*	**	•
17. Behavior in childhood fights	•	•	*
TOMBOYISM			
18. Known to self and mother as tomboy	*	**	•
19. Satisfaction with female sex role	•	*	•

Legend:
PI=Progestin-induced hermaphroditism (N=10)
AGS=Adrenogenital syndrome (N=15)
TS=Turner's syndrome (N=15)
C=Matched controls
(*)=p < .10
*=p < .05
**=p < .01
•=No significant difference

References

1. Doerner, G.: "Tierexperimentelle Untersuchungen zur Frage einer hormonellen Pathogenese der Homosexualität." (Tr.: Animal experimental studies on the question of a hormonal pathogenesis of homosexuality.) *Acta biologica et medica Germanica*, 19:569-584, 1967.

2. Ehrhardt, A. A.: "Der Einfluss von fötalen Hormonen auf Intelligenz und geschlechtsspezifisches Verhalten." (Tr.: The effect of fetal hormones on intelligence and sex-related behavior). In: PRAXIS DER KLINISCHEN PSYCHOLOGIE, BAND II (E. Duhm, ed.). Göttingen, Verlag für Psychologie, Dr. C. J. Hogrefe, 1971.
3. Ehrhardt, A. A., Epstein, R. and Money, J.: "Fetal androgens and female gender identity in the early-treated adrenogenital syndrome," *The Johns Hopkins Med. J.*, 122:160-167, 1968.
4. Ehrhardt, A. A., Evers, K. and Money, J.: "Influence of androgen and some aspects of sexually dimorphic behavior in women and with the late-treated adrenogenital syndrome," *The Johns Hopkins Med. J.*, 123:115-122, 1968.
5. Ehrhardt, A. A., Greenberg, N. and Money, J.: "Female gender identity and absence of fetal gonadal hormones: Turner's syndrome," *The Johns Hopkins Med. J.*, 126:237-248, 1970.
6. Ehrhardt, A. A. and Money, J.: "Progestin-induced hermaphroditism: IQ and psychosexual identity in a study of ten girls," *J. of Sex Res.*, 3:83-100, 1967.
7. Goy, R. W.: "Experimental control of psycho-sexuality," *Philosoph. Trans. of the Royal Soc. of London*, B, 259:149-162, 1970.
8. Harris, G. W.: "Sex hormones, brain development and brain function," *Endocrin.*, 75:627-648, 1964.
9. Money, J.: "Psychologic approach to psycho-sexual misidentity with elective mutism: Sex reassignment in two cases of hyperadrenocortical hermaphroditism," *Clin. Ped.*, 7:331-339, 1968 a.
10. Money, J.: *SEX ERRORS OF THE BODY: DILEMMAS, EDUCATION AND COUNSELING*. Baltimore: Johns Hopkins Press, 1968 b.
11. Neumann, F. and Elger, W.: "Permanent changes in gonadal function and sexual behaviour as a result of early feminization of male rats by treatment with an antiandrogenic steroid," *Endokrinologie*, 50:209-225, 1966.
12. Whalen, R. E. (ed.): *HORMONES AND BEHAVIOUR*. Princeton: D. Van Nostrand Company, Inc., 1967.

Breast cancer

This is the leading cause of cancer incidence and death in women today. There will be an estimated 71,000 new cases in 1972 and an estimated 32,000 deaths. Seven of every 100 American women will some day develop the disease.

The greatest progress in the treatment of breast cancer has come in the past few decades. Surgery, hormone therapy, radiation, chemotherapy and combinations of methods are used. Detection practices range from breast self-examination—95% of patients discover their condition themselves—to mammography and thermography, which employ X-ray and heat pattern techniques, respectively.

Despite all efforts to date, the breast cancer death rate remains high. This could change for the better if more women regularly practiced self-examination and consulted their physician at the first symptom. Although breast cancer is usually found in women of middle age and over, who are the main educational target, the Society recommends that efforts also be directed toward educating girls of high school age.

Physicians know that earlier detection could save more lives, that the stage at which breast cancer is detected is crucial to the outcome of treatment. There is an approximately 85% survival of five years when breast cancer is treated before it spreads to the lymphatic system. The percentage of those localized tumors increased from 38% in the 1940s to 46% in the early 1960s, while survival rates increased slowly but steadily among patients with regional spread. Between 65 and 80% of those biopsied for breast tumor are found to have a benign condition.

Local Units of the Society are encouraged to conduct special public and professional educational projects on breast cancer in order to emphasize to the physicians and women of the community the importance of regular physical examinations and to teach and encourage the practice of **Breast Self-Examination**, title of the Society's most popular film. Films and filmstrips are available for various age groups. The film **Recovery After Mastectomy** has proved a great aid to those returning to their jobs and homes following surgery. A new pamphlet, **A Breast Check**, describes a simplified BSE technique. A 10-minute color film **Five Minutes for Breast Self-Examination**, is directed specifically to low-income, inner-city, hard-to-reach mass populations.

By FREDERICK BURG, M.D., AND EUGENE DIAMOND, M.D.

Car restraint devices designed for children

ANY DOCTOR WHO has child patients should spend a few moments with the patient's family urging the purchase and use of properly designed, restraining devices in the car for the children. If not properly instructed, the family may think the equipment superfluous or may purchase inadequate devices.

A properly designed restraint system provides maximum protection at impact and deters the child from distracting the driver with his behavior. The device should be constructed to provide a long, smooth period of deceleration during collision or sudden braking and to prevent ejection of the child from the automobile.



Figure 1



Figure 2



Figure 3



Figure 4

A child's size and weight generally determine the most appropriate type of auto safety restraint for him. Infants or children should be placed in the rear seat, unless an infant carrier (Fig. 1) is used. When an infant carrier is not used, babies unable to sit up and weighing less than 12 pounds should be placed in a car bed in the back seat with the axis parallel to that of the automobile. (Fig. 2) The infant's feet should point toward the front of the car. A strong net-

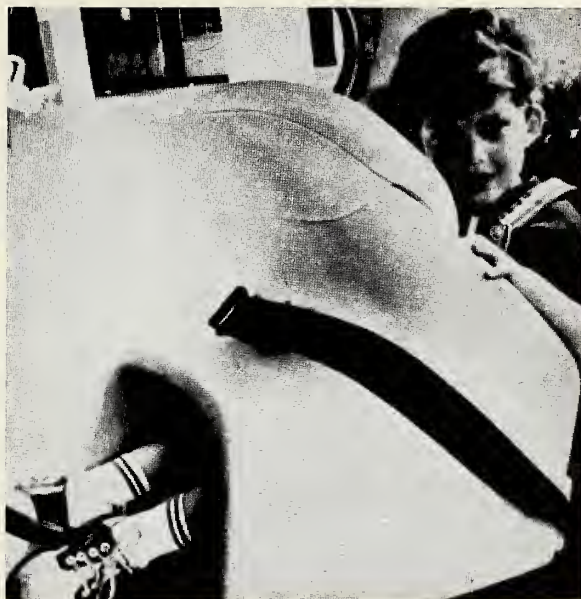


Figure 5

ting should cover the bed, and the middle front and rear seat belts wrapped around the legs of the bassinet to secure it.

For the 12-to-24 pound child an adequately designed safety harness restraining the child across the high-chest and pelvic areas is recommended. (Fig. 3) A loose netting connecting the pelvic and chest straps provides support for the abdominal area, and the safety harness provides mobility. An abdominal strap should not be used, since it could injure the child's viscera during deceleration. A more convenient but more restrictive alternative is a toddler seat. (Fig. 4)

A good safety seat is recommended for children weighing from 25 to 50 pounds. At present the shield-type seat design gives the best protection (Fig. 5), but some children object to this device because it limits their field of vision.

Children who weigh more than 50 pounds and who are less than 55 inches tall should use an adult safety belt but no shoulder harness, since the harness crosses the chest too near the cervical region and can cause neck injuries in an accident. Any child taller than 55 inches may use both the adult seat belt and the shoulder harness. ◀

FREDERICK BURG, M.D., (not shown) is assistant professor of pediatrics at Northwestern University.

EUGENE DIAMOND, M.D., (right) is professor of pediatrics at Loyola University Stritch School of Medicine and a member of the American Academy of Pediatrics.





editorials

Sudden death . . . premonition of things to come

A committee of physicians from several heart associations has agreed on a definition of sudden unexpected (natural) death. It is: "death occurring instantaneously or within 24 hours of the onset of acute symptoms or signs."¹ This is a satisfactory definition and may be the first step toward the solution of one of medicine's most baffling problems. It has been estimated that each year out of 600,000 deaths from arteriosclerotic heart disease, 60% of the victims die before they reach the hospital. Furthermore, half of those covered by this definition succumb before the ambulance or a physician can be reached.

Sudden death is said to be the initial clinical manifestation of coronary disease in 20 to 25%. The remainder—75%—have angina pectoris or are survivors of myocardial infarction. It is the group known to have heart disease that we might be able to help in the future. It was surprising how many saw the physician the week before they died. It is here that we might obtain a helpful clue. Some complained of vague chest pains or discomfort or had premonitory symptoms indicative of impending death. These were new chest symptoms or aggravation of old ones. The fact that the electrocardiogram did not change meant nothing.

In one report,² 17% of the patients (who died suddenly and without a previous history of heart disease) had consulted a physician the previous week. Apparently, they had a premonition that something was going to happen. In less than five per cent, sudden death was preceded by vigorous physical activity.

No fresh thrombi were found in the coronary arteries in the majority of autopsies performed on those dying abruptly. As a result, the most likely cause of death was ventricular tachycardia

or fibrillation or sinus node arrest.

We must recognize the significant premonitory symptoms that take place in the week before death. Chest pain may be, but is not necessarily, indicative of impending or actual infarction. Many of these victims had observed a sense of pressure, tightness, burning, squeezing or other chest discomfort. The significance of dull chest pain should not be discounted, especially when it brought the patient to the physician. Episodes of faintness, weakness, dyspnea, indigestion or profuse sweats should also be viewed with suspicion.

Many of these individuals should be hospitalized and monitored, preferably in a coronary care unit. In this way, a possible arrhythmia leading to sudden death can be detected and treated promptly. After all, every myocardial infarction is not ushered in with crushing chest pain, pain radiating down the left arm, waxy pallor and changes in the electrocardiogram. Be suspicious, especially when manifestations of a minor degree develop in a person with previous heart disease and a number of high risk factors. Hospitalization may create undue anxiety, but enough people are dying to take this chance. The benefits of the self administration of drugs, such as atropine or lidocaine to prevent arrhythmias, is not known. It may, however, save some lives.

T. R. Van Dellen, M.D.
Editor

References

1. Oglesby Paul & Michael Schatz.: "On Sudden Death," (Editorial) *Circ.* Jan. 1971, pgs. 7-10.
2. "Stepping Up Research on Sudden Death," *Med. World News*, Feb. 19, 1971, pgs. 38G & 38J.



membership forum

ISMS where do you stand on abortion? . . .

February 17, 1972

Dear Editor,

In the near future bills will be introduced into the State Legislature to change the Illinois abortion law. Recently a 15-year-old girl had to be transported to New York for a medical procedure deemed necessary by her physician but denied by Illinois.

My trips to Springfield and my long discussions with legislators in Chicago have convinced me that the position of ISMS carries a great deal of weight with legislators. I have been told over and over again, "Get the ISMS to declare that abortion is a medical procedure, not a crime."

Now that the AMA has taken an unequivocal stand that abortion is a medical procedure, I do not understand the hesitance of the ISMS to make clear that abortions performed by a li-

censed physician should not be governed by criminal law.

I read with interest your policy statement on abortion as it appeared in the *Illinois Medical Journal*, January, 1972. Since the only argument used to support the Illinois abortion law is that abortion is the "taking of an innocent human life," it seems safe to assume that ISMS disagrees with this position and is offering indications for a medical procedure, not justifications for such a serious criminal act.

Please make it clear that the ISMS policy statement is a guideline for PHYSICIANS; that ISMS does not advocate indications for abortion be included in the Illinois criminal code.

Sincerely,

Lonny Myers, M.D.

Midwest Population Center

Doctors, you must solve maldistribution . . .

October 15, 1971

Dear Editor:

You have a big job on your hands if you are to tell the legislature how to solve the maldistribution of medical care. I do not think it can be solved by a law. I think *WE* must solve it.

Forty years ago, distribution was automatic, every doctor who graduated looked for a neighborhood or town that needed a doctor. As a result—a doctor over every drugstore. Gradually as the doctors limited their work to a specialty, they moved to medical centers where X-ray and laboratory help were available. Also, gradually the rest of the profession saw the need for sophisticated equipment, so they too moved to the centers where these services were available. As a result, there were no doctors in the residential areas, doctors did not live near their offices.

The hospital could not escape, so the hospi-

tal became the general practitioner for the neighborhood, nights and week ends. In poor communities, the hospital had to take over completely. The rural poor and the rural rich lost their doctor to the city where he had equipment, consultation and medical companionship. He could also hide on weekends because very few of his patients knew where he lived.

How do we solve the problem?

1. Graduate 20,000 doctors a year instead of eight or 10 thousand, so we have competition, enough to fill all of the spots.
2. Reduce our residencies in the specialties so only 50% of our graduates become specialists. The other 50% become family practitioners. (We would still have as many specialists as we do now, the increase from 10,000 to 20,000 graduates would be in generalists.) This would require a ruling by

Doctors and maldistribution

the Liaison Committee of our Council on Medical Education and the Association of American Medical Colleges, together with the Council of Medical Specialties.

3. Group practice has increased four-fold in the past decade, for a number of reasons, one of which is federal programs. Group practice will increase rapidly. We should encourage groups of 20 physicians to locate in 20,000 population centers. They will bring with them the equipment enabling them to be a self-contained medical center. There will still be enough doctors left over to man the teaching and the secondary referral centers.

Each neighborhood facility should be manned by 50% generalists. They will be able to deliver more units of service at less cost than the specialist—but consultation will be immediately available.

4. Have the neighborhood facility open 24-hours a day, seven days a week. Employ a male nurse, corpsman or senior medical student to live in the facility to do the night and week-end emergency work. One or more members of the group should be available, at the ball game, show or cookout, even on weekends.

How about the small town? A survey in Iowa revealed that almost no one in Iowa is over 25 minutes from medical care. Nevertheless, every county seat should have one or more group

practices with satellite offices where a generalist could go several days per week, and if needed, a pediatrician or internist. A local nurse should live in the town, she could respond and transmit an EKG by phone, nights and weekends. She could control bleeding or clear an airway until the helicopter arrived. The small town will never again have a solo family physician. It is too lonesome a job, and too confining.

I have talked about this at meetings across the country, one of which was conducted by our Council on Rural Health. I have talked to members of AAMC and our Council on Medical Education. Gradually they are beginning to listen. I have had three replies in the past few weeks that seem to agree with the reduction in number of residents in our specialty training programs.

I have also suggested that all family practice residencies be in hospitals that have no training programs for the other specialties. The GP residency should be in a community general hospital where primary care is predominant. After two years, he should go into an apprenticeship in a GP group, a mixed specialty group or with a solo family practitioner for a year. Then he would be ready to go it alone, or stay in group practice.

Best to you in your endeavor.

Cordially,

Walter C. Bornemeier, M.D.

The absence of mental illness

Mental health signifies the absence of mental illness, an ability to adapt personally and collectively to the given environment, both allo and auto-plastically; an ability to mature and fulfill potentials, which includes loving and being loved; and a demonstrable ability to expend a given quantum of psychic energy (libido) on a hierarchy of interests, ranging in amount and quality of investment from self, to others, from people to things animate and inanimate; from emotional cathexis to intellectual ones and from micro to macro environments. This means, perhaps most significantly, living with a degree of uncertainty without conversion to the certainty of faith. It means, most importantly, living not in rigid but in flexible homeostatic balance, and charging, according to appropriateness of adaptive demands, the contrasting opposite qualities in oneself. This kind of balance would make one aggressive but not hostile; pacific but not cowardly; expressive without being verbose; honest and good but not saintly; generous but not gullible; tolerant but not weak; sensuous but not lecherous or greedy; individuated yet also socialized. It also means possessing a stable identity, increasing in definition with age, and preserved for the longest time, yet sufficient flexibility to be relatively unpredictable in unusual circumstances. . . ." (Daniel Cappon.: *Mental Health in the High-Rise, Canadian JI. of Public Health*, Vol. 62 Sept./Oct., 1971, pgs. 426-431.)

Mylanta[®] 24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.

Mylanta[®]

LIQUID/TABLETS

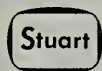
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance

Relieves G.I. gas distress*

Non-constipating

*with the defoaming action of simethicone



PHARMACEUTICALS Pasadena, Calif. 91109

Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899



Ulcerative colitis

(Continued from page 360)

References

The bibliography for this article may be obtained by contacting the office of the *Illinois Medical Journal*, 360 N. Michigan Avenue, Chicago 60601; (312) 782-1654.

the view box

(Continued from page 361)

Diagnosis: Pulmonary Alveolar Microlithiasis—Radiographically these are diffuse miliary nodulations with an alveolar configuration. With progression of the disease the nodules become more numerous and dense especially in the lower lobes. Calculi may fill completely all the alveoli of individual acini, producing nodules up to 5 mm. in diameter. The lung bases may become stony dense and completely obliterate the heart, diaphragms, and lower lung detail as seen in our case.

The diffuse alveolar nodulation of calcific density is highly characteristic. When associated with an obliterative density in the bases, the picture is virtually pathognomonic of microlithiasis.

In this rare familial disorder, minute calculi are deposited progressively and diffusely within the alveoli of both lungs. Although generally asymptomatic, the condition can sometimes produce respiratory symptoms in childhood, or may lead to late symptoms from complicating fibrosis, emphysema, or right heart failure.

Pancreatic transplantation

(Continued from page 365)

Renal function is impaired early and manifests itself as falling creatinine clearance, falling urine volume and decreased sodium excretion. Pancreas rejection barely manifests itself at all but would be characterized by hyperamylasemia and hyperglycemia if allowed to progress. In our current human experience, pancreatic ascites seems to be the earliest sign of pancreatic rejection. In the X-ray films shown to us today, we see the early manifestations of duodenal rejection. These are characterized by severe mucosal edema and swelling of the graft.

This is an example of lessons that can only be learned by performing pancreas transplantation in man. ◀

PFIZERPEN DOSAGE FORMS



**Orange-flavored
Pfizerpen VK for Oral Solution
(potassium phenoxymethyl penicillin)**
125 mg. (200,000 units)/5 cc.:
bottles of 100 cc. and 150 cc.
250 mg. (400,000 units)/5 cc.:
bottles of 100 cc. and 150 cc.

**Pfizerpen VK Tablets
(potassium phenoxymethyl penicillin)**
250 mg. (400,000 units): bottles of 100.
500 mg. (800,000 units): bottles of 100.



**Butterscotch-caramel-flavored
Pfizerpen G Powder for Syrup
(potassium penicillin G)**
400,000 units/5 cc.:
bottles of 100 cc. and 200 cc.

**Pfizerpen G Tablets
(potassium penicillin G)**
200,000 units: bottles of 100 and 500.
250,000 units: bottles of 100.
400,000 units: bottles of 100 and 1000,
and unit-dose pack of 100 (10 x 10's).
800,000 units: bottles of 100.

in the presence of spasm or hypermotility,
gas distension and discomfort, **KINESED®**
provides more complete relief:

- ☐ belladonna alkaloids—for the hyperactive bowel
- ☐ simethicone—for accompanying distension and pain due to gas
- ☐ phenobarbital—for associated anxiety and tension

Composition: Each chewable, fruit-flavored, scored tablet contains: 16 mg. phenobarbital (warning: may be habit-forming); 0.1 mg. hyoscyamine sulfate; 0.02 mg. atropine sulfate; 0.007 mg. scopolamine hydrobromide; 40 mg. simethicone.

Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.

Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or uri-

nary bladder atony. Prolonged use of barbiturates may be habit-forming.

Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

Dosage: Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.



STUART PHARMACEUTICALS | Pasadena, California 91109 | Division of ATLAS CHEMICAL INDUSTRIES, INC.

(from the Greek *kinetikos*,
to move,
and the Latin *sedatus*,
to calm)

KINESED®
antispasmodic/sedative/antiflatulent



practice management

Will your records satisfy the "Tax Man"?

R. ALLEN DIENER/SENIOR CONSULTANT
PROFESSIONAL BUSINESS MANAGEMENT, INC.
67 EAST MADISON STREET, CHICAGO 60603; 782-2282

As most of us settle back from the pressures of filing last year's income tax returns, our thoughts often turn to more pleasant things. But, have you ever pondered whether that return will come back to haunt you sometime within the next three years?

Assuming personal income and deductions are all properly substantiated and reported, (as most usually are, due to the IRS requiring statements to taxpayers for dividends, interest and wages paid) how would those practice records look to the skeptical auditor, trained to ferret out unreported income or unsubstantiated practice expense?

To clear this very real hurdle in the event of "Uncle's" review, an orderly system of cash receipts and disbursements is vital.

Ground rules

Ground rules must be laid and strictly adhered to. All charges to patients and reductions or refunds thereof must be recorded. All cash receipts must be accounted for in a duplicate numbered receipt book. All practice expenses should be paid by check from this same account. (Minor items such as postage due, paper clips, etc., may be paid from a petty cash fund of about \$25.)

Charges and receipts system

The first element of an "audit proof" records system involves the use of a chronological record of charges and receipts commonly known as a "day sheet." Each patient's name, brief description of service rendered and amount of charge and/or receipt is entered thereon. Mail receipts

are likewise recorded on this form. At the end of each day, totals are recorded at the bottom of the form. Your girl should then post all charges and receipts to the "patient account card" maintained by name of responsible party—usually the head of the household. These cards should be maintained in alphabetical sequence in a file separate from your patient records for ease in month-end billing. Billing can be accomplished either through use of typewritten statements or a photocopy system.

The third element to a good accounting system is the "record of cash receipts." Daily totals from the day sheets are entered thereon as well as non-practice cash receipts. Bank deposits should be made regularly in amounts equaling exactly the total receipts for a given day or group of days. Monthly receipts columns should equal the deposit column. Use of these forms, coupled with the requirement that your aide give each patient a receipt for cash payment, should convince any probing auditor that it is your conscientious effort to record (and report) all taxable practice income.

Disbursements systems

Your checkbook should be of the "commercial" type which includes a check stub with sufficient room for recording reasons for various expenditures. All checks should be posted in numerical (and chronological) sequence on a "disbursements record" indicating date, name of payee, check number, amount and expense category. Monthly, all columns should be totaled and cross balanced. Check numbers and date of

(Continued on page 402)

Something new
in ampicillin
therapy:
low cost



Versapen-K
POTASSIUM HETACILLIN

the ampicillin derivative

Each capsule contains potassium hetacillin equivalent to
225 mg. or 450 mg. ampicillin.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

May clinics listed for handicapped

Thirty-two clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will hold 24 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions, and three for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

May

- 2 Belleville—St. Elizabeth's Hospital
- 2 Fairfield—Fairfield Memorial Hospital
- 3 Hinsdale—Hinsdale Sanitarium
- 3 Springfield Pediatric Neurological—Diocesan Center
- 4 Sterling—Sterling Community Hospital
- 4 Effingham—St. Anthony Memorial Hospital
- 4 Litchfield—St. Francis Hospital
- 4 West Frankfort—Union Hospital
- 4 Peoria Cardiac—St. Francis Hospital
- 9 Peoria—St. Francis Hospital
- 9 E. St. Louis—Christian Welfare Hospital

- 10 Joliet—St. Joseph's Hospital
- 10 Champaign-Urbana—McKinley Hospital
- 11 Rockford—Rockford Memorial Hospital
- 11 Springfield—St. John's Hospital
- 11 Macomb—McDonough District Hospital
- 12 Chicago Heights Cardiac—St. James Hospital
- 16 E. St. Louis—Christian Welfare Hospital
- 16 Rock Island Area General—Moline Public Hospital
- 17 Evergreen Park—Little Company of Mary Hospital
- 18 Pittsfield—Illini Hospital
- 18 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 18 Decatur—Decatur Memorial Hospital
- 18 Anna—Union County Hospital
- 22 Peoria Cardiac—St. Francis Hospital
- 23 Peoria General—St. Francis Hospital
- 24 Elgin—Sherman Hospital
- 24 Springfield Pediatric Neurological—Diocesan Center
- 24 Centralia—St. Mary's Hospital
- 26 Chicago Heights Cardiac—St. James Hospital
- 31 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
- 31 Carmi—Carmi Township Hospital

Your records and the Tax Man

(Continued from page 400)

payment should be indicated on the face of all invoices, which should be filed in an orderly manner in the office. Any disbursement which may raise future questions should be explained fully either on the invoice or on the check stub.

At month's end, your aide should balance the bank account, retaining the cancelled checks and bank statement with the bank reconciliation so an auditor can follow the "audit trails" through the various records to a final and early conclusion of his audit.

Payroll

Employee payroll data should be neatly and accurately recorded on a suitable "payroll record."

Equipment purchases

Purchases of depreciable furniture and equipment should also be recorded on a suitable "equipment record."

Additional benefits

In addition to satisfying the tax man, these records provide the necessary data for you to determine your monthly net profit, collection and expense ratios, and to easily accumulate annual totals for tax reporting. The job of preparing employee tax returns and estimating quarterly income tax payments is also made easier, thus decreasing the possibility of penalties for underpayment of estimated taxes.

Your use of these systems "tightens up" office operations, decreasing the possibility of theft or embezzlement and provides a stimulus to your aide to maintain current, complete and accurate records.

If desired, you may utilize the services of a professional management consultant or accountant to review records, providing periodic "operating statements" and other interpretations of the data accumulated for better practice management and control. Then you can really settle back after filing next year's tax return! ◀

What "health care crisis?"

(Continued from page 344)

And while we're at it, we could point out that during the 1971 fiscal year the share of the health care dollar received by physicians continued its seven-year decline. The Social Security Administration reported that physicians received 19 percent of the total funds spent for health care. That was down from 21.5 percent in 1965.

Yes, . . . health care costs are increasing, all right! In 1950, for example, a house painter had to work 23 and a half hours to pay for his child's tonsillectomy. In 1970, he had to work only 18 hours and 49 minutes to pay for a tonsillectomy.

In 1960 a plumber had to work 39 and a half hours to pay the obstetrician for the delivery of a baby. Delivery of an infant in 1970 cost him only 34 hours and 43 minutes of work.

But all these things are irrelevant and immaterial. Our friends in Washington still insist there is a crisis in health care, and the government offers the only hope of solving all our problems.

Well . . . they can certainly point to some singular successes!

Confronted with a shortage of physicians . . . the federal government for seven years running slashed fiscal grants to medical schools! This year, they loudly proclaim medical student assistance funds were increased by a whopping \$6 million while capitation grants . . . the new form of institutional support for medical schools . . . went up an even more impressive \$10.7 million.

It is perhaps unfair to point out that medical schools will get \$161 million less in construction funds this year than last, or that the total federal budget for new health manpower has been cut by \$141 million . . . all the way down to \$532 million for fiscal 1973.

Right here in Illinois, the record is no less impressive. While Illinois ranks *fifth* in population and *fourth* among the states in per capita income, we rank *39th* in state expenditures for medical school expenses.

And the new U of I branch campus plan referred to earlier may never get off the ground. In its wisdom, the Board of Higher Education has recommended a requested \$8.5 million increase in U of I operating funds be cut to \$7 million, with most of that earmarked for inflationary increases. And the \$14.5 million requested for private medical education would be cut

to \$7.8 million if the Board of Higher Education has its way.

That is the federal success story that some politicians would expand into a national health care system. Ah yes . . . nationalized health care. Would it make health care delivery more efficient? Would it improve the quality of care? Would it be less costly?

For the answers let's look at our agricultural system. Washington started playing with that in the 1930's.

Today . . . more than 40 years later . . . the government has the ultimate answer: pay farmers NOT to grow crops!

There IS a shortage of health care in the ghetto . . . and there's a shortage of food, jobs, education and family income as well.

There IS a shortage of physicians in small towns . . . but not every small community NEEDS a doctor. Modern transportation puts many of these communities within minutes of nearby medical centers.

Health care IS costly . . . but so are intensive care units, cobalt machines and all the other equipment needed to provide modern health care, not to mention the salaries of technicians to operate the equipment. And the medical skills with which we increased our life span also increased costs because older patients NEED more health care.

And somewhere along the line . . . buried by all the clamor of the public for its rights . . . including the right to health care . . . public accountability has been lost!

The public's demand for health care services *increases* as its responsibility to pay for that care *decreases*. If the care is subsidized by government or even private health insurance, the sky's the limit. Our offices are filled with the walking well and the nearly sick.

And if mother wants to stay in the hospital for another week . . . why not? It's paid for. Let Uncle Joe stay in the hospital for two more days . . . until we finish redecorating the inside of the house. Let's depend on the government to take care of Grandpa . . . we can't do anything for him at home.

To add frosting to the cake, let's get fat, drink too much, smoke two packs a day and drive too fast. Then we can take our heart attacks, strokes, cancerous lungs and mangled limbs down to the hospital for a miracle cure that someone

What "health care crisis?"

else is paying for. Nothing can be done, of course, for the 50,000 Americans killed in traffic accidents each year.

Well . . . all of these are health care problems . . . gentlemen. And that's what we have in this country today . . . HEALTH care problems . . . not MEDICAL problems . . . HEALTH CARE problems.

I think we have these problems because our greatest strength is also our weakness. Here's what I mean.

Key to action is unity

The most important tool for practicing good medicine lies within ourselves . . . and that is individualism. This is not only the bedrock of free enterprise, but the cornerstone of the doctor-patient relationship as well.

But individualism does not lend itself to COLLECTIVE action. It does not lend itself to the UNITY and COOPERATION that our profession so sorely needs in these troubled times.

Physicians too are embroiled in a race revolution, a youth revolution, a moral revolution and in the most far-reaching technological revolution in history.

Like it or not, we can no longer bury ourselves in our individual practices and say: THIS is medicine. No . . . we must put aside our individualism and act in CONCERT to help solve larger health care problems.

The medical practice of tomorrow will be what ALL OF US, acting in unity and in strength, choose to make it. And what medicine becomes involves not only all physicians, but all patients as well.

Tragically . . . we have yet to muster that unity . . . and that strength! At a time when even more government intervention threatens medicine . . . we stand DIVIDED!

At the most crucial period in our history, when we need to act as one voice, one mind, one strong arm . . . we DISINTEGRATE into splinter groups.

We complain about government intervention in medicine . . . about our county society . . . about our state society . . . about the AMA. As a result OTHERS speak for us.

The Council of Medical Staffs speaks for us. The American Association of Physicians and Surgeons speaks for us. The Medical Committee on Human Rights speaks for us. Even the American Hospital Association speaks for us.

All these voices speak out . . . but our voice is weak.

The government limits our fee increases to 2.5% a year while institutions which employ salaried physicians may increase their charges to 6%. We protest . . . but our voice is weak.

The same federal government says that unpaid patient bills cannot be written off on taxes because health care delivery is a service. At the same time, we are told to post our fees on the office wall as if we were dispensing a product. We protest . . . but our voice is weak.

The government increases fiscal emphasis on a prepaid, closed-panel type of health care delivery system called the HMO. We can live with HMO's. This IS a pluralistic system. But the blanket promotion of HMO's is another matter. There are more than 30 right here in Illinois.

We protest . . . but our voice is weak.

All these things have occurred because there is a vacuum in socio-economic leadership within our profession . . . and each of us is partly to blame. This happens because the system we are trying to preserve . . . the right to private enterprise in medicine . . . sometimes blinds us to other problems.

We allow ourselves to become . . . in the government's own words . . . merely health care providers. Well . . . I don't know about you . . . but I'm sick and tired of being JUST a provider.

Let's be health care DESIGNERS! Let's be health care PLANNERS! Let's be health care LEADERS!

Let's support our programs

Let's join . . . and support . . . our local and state foundations. Through our foundations, we ARE designers of health care. We CAN lead the way in preserving the best features of our present system and effect changes to ease existing problems.

We should support voluntary peer review . . . the life blood of the foundation program. We MUST make peer review work. Who else is QUALIFIED to counsel physicians but other physicians? Peer review can be an educational tool in our hands . . . or a club over our heads in government hands.

Remember this . . . our foundations are designed and administered by we physicians. They give us a strong voice in how private or government health care programs will operate. And

they give us the strong arm we need to **NEGOTIATE** health care service contracts.

The first major foundation project is the program of HASP. I'm sure you're familiar with why HASP was conceived, and how it operates.

By monitoring the length of stay of medicaid patients . . . we hope to reduce expensive hospitalization costs. The foundations . . . and the HASP program . . . are not perfect.

No undertaking of this magnitude is without problems. But let's work from **WITHIN** . . . not without. These are problems that we can work **TOGETHER** to solve.

Just as the foundations and HASP were designed by us, they **CAN BE ALTERED** by us! But don't just stand by and complain. Contribute! Tell us a better way. But make sure it **IS** a better way!

When you stop to think about it, why **SHOULD** any patient be hospitalized longer than necessary? Hospital care **IS** expensive. And why **SHOULDN'T** it be we physicians who determine how long a hospital stay should be?

We should also support our medical society legislative programs. Enlightened approaches to health care problems require knowledgeable lawmakers who understand the health issues facing our state.

How can we get such legislators? How can we make our voice heard in the legislative chambers where government health care policies, opinions and programs are formed?

ANY increase in the number of lawmakers sympathetic to **REAL** health care problems would make a significant difference.

And this election year is a critical one in our struggle to keep medicine free. So let's **MAKE** our voices heard . . . in our own communities . . . in Springfield . . . in Washington. Let's support our medical society political action committees.

AMPAC and **IMPAC** can use all the help they can get in supporting candidates who believe that health care delivery changes should put **QUALITY FIRST** . . . and **COSTS** second.

That's where the political action is . . . in our political action committees . . . and that's what we should support!

Last spring the legislature asked **US** for recommendations on how **THEY** can help solve health care problems.

Our Task Force on Physician Shortage made a six-month study . . . and gave the state our recommendations. Now let's see what they do with them.

We've asked the state to establish a Division

of Health Manpower Recruitment. Its major purpose would be to work **WITH** us in defining areas most in need of help. Then a priority list will be set up to most effectively utilize health manpower.

This may eventually help ease health care problems in the ghetto and small towns. A ruptured appendix is just as serious in Huntley or Nauvoo as it is in Rockford or Rock Island.

We urged the state to enact legislation to make the medical climate more favorable in Illinois. One way would be to update malpractice laws . . . such as the statute of limitations on filing of suits. We've asked that it be limited to three years after date of actual injury rather than two years after discovery.

We also asked that plaintiffs in malpractice suits be required to post a \$500 surety bond as evidence of good faith. We also believe the plaintiff should be required to verify his pleading under oath. If the pleadings proved false, the plaintiff could be charged with perjury.

Contribute our knowledge to others

There are other ways we can contribute. We can make our expertise and knowledge available to local health care planning groups. I mean Comprehensive Health Planning groups . . . but not as they function now . . . from the top down!

I mean health care planning from the bottom up . . . planning that emphasizes **LOCAL** problems and **LOCAL** solutions . . . planning in which the roots feed the branches and not vice versa.

And I mean health care planning where local **RESPONSIBILITY** is matched by local **AUTHORITY**!

Well . . . how do we achieve all these things? We know it won't be easy . . . we **DO** have our own practices to worry about. We **DO** work long hours. We **DO** have to keep up with medical education.

How do we achieve these things? We **MUST** stand together. The day has come when we desperately need all the unity and strength we can muster. The day has come when **WE** should propose a revolution in health care.

And that revolution should be in the socio-economics of health care. Remember this too. If **WE** are to be strong . . . if **WE** are to lead . . . then our good right arm . . . our home office staff . . . must be equally strong.

In the past six years this society has added just one person . . . one person . . . to our staff. If socio economics in medicine is the game . . . then **LET'S PLAY WITH A FULL DECK!**

What "health care crisis?"

Let's expand our socio-economic division. Let's get our people out in the thick of things . . . out where our friends . . . and our enemies . . . are.

If we need a Socio-Economics Council, let's have it. If we need a Committee on HMO's let's have it. But let's have the staff to back it up too.

Can we afford it? This medical society is the fourth largest in the nation . . . but it ranks 37th in ratio of staff to society members. And while only three other state medical societies are larger than we are in total membership, we rank 19th among state medical societies in membership dues.

We can't afford NOT to increase our dues.

Let's shape our future

Let's not wait to be TOLD what's going to happen in health care. Let's KNOW what's going to happen. Let's SHAPE what's going to happen.


Let's act in UNITY . . . and in STRENGTH.

It has been said that today is the first day of the rest of our lives. Well remember this. If . . . in what we do here today . . . we grow weaker rather than stronger . . . then today could be the beginning of the last day of our lives as physicians practicing in a pluralistic system.

We are part of all that happens. Our future lies in building the strongest organization we can . . . and in doctors who have the courage, strength and compassion to make health care in this state better than it's ever been.

We must be more than doctors to our patients. Let's be the doctors of our destiny!

I welcome your counsel . . . and your support . . . in the difficult year ahead. We stand . . . or fall . . . together.



Illinois physicians' cooperation needed in reporting deaths due to cancer

The American Cancer Society is asking Illinois physicians to cooperate in reporting specific facts on deaths due to cancer.

The Cancer Society is reactivating its great epidemiological landmark project—its six-year Cancer Prevention Study of 1959-65—which has provided an enormous fund of data about America's health profile.

The purpose of the original study was to obtain leads on environmental factors responsible for the occurrence of cancer, which scientists believe to be a multiplicity of diseases with different causes and combinations of causes. The revitalized study is being conducted for this same reason and because of changes in the ecological conditions. Cancer typically does not become

manifest until many years after initial exposure to the environmental agent which may cause it. By tracing people for a very long time the chances of discovering the various causes of cancer are greatly increased.

The detailed data supplied by physicians will permit: analysis of factors related to less common sites of cancer; and analysis of the effect of changes in cigarette smoking on death rates. (29 million Americans have quit smoking as a result of the Cancer Society's campaign.)

Illinois doctors are asked to contact the following individuals in supplying the requested information: Drs. Paul Holinger, Walter L. Palmer, Robert L. Schmitz, T. Howard Clarke (all Chicago physicians); and Willard C. Scrivner, East St. Louis.

Obituaries

Adair, Fred L., Oklahoma City, died Feb. 13, at the age of 94. He was a founder and former president of the American Congress of Obstetricians and Gynecologists, and a long-time Chicago educator and physician.

***Baker, Morton**, Chicago, died Feb. 15, at the age of 58. He was chief radiologist at Walther Memorial Hospital and former chief-of-staff.

***Crosby, Edwin L.**, Winnetka, died Feb. 20, at the age of 63 of a circulatory disease. He was director of the American Hospital Association for the last 16 years and the first director of the National Joint Commission on Accreditation of Hospitals.

***Engelhard, Herbert H.**, Evanston, died in February at the age of 70. He was on the staff of St. Francis Hospital in Evanston.

Feinberg, Isadore M., died in February at the age of 75. He was a physician, surgeon, pharmacist, embalmer, and funeral director, and taught medicine at Loyola University.

***Finne, Burton A.**, Wilmette, died Feb. 19, at the age of 67. He was a physician for E. I. du Pont de Nemours & Co. for 30 years.

***Greenspan, Irving**, died Feb. 12, at the age of 48 while vacationing in Hawaii. He was known for his research in developing a new treatment that successfully arrested leukemia by transfusing healthy white blood cells into the patient, with a team of physicians at the Chicago Medical School.

****Hirsch, Edwin F.**, Chicago, died March 5, at the age of 85. He was a leading pathologist and director emeritus of laboratories for Chicago's Columbus-Cuneo-Cabrini Medical Center.

Kassel, Myrna B., Chicago, died Feb. 22, at the age of 53. She was director of the state Labor Department Human Services Manpower Career Center and previously an assistant director in the Illinois Department of Mental Health.

Le Pak, Alfred J., Glen Ellyn, died Feb. 22, at the age of 59. He had been a member of the Federal Aviation Administration Medical Examining Board in Chicago since 1960.

***McDermott, Raymond A.**, died in February

at the age of 77. He was formerly chief medical examiner in Chicago for the New York Life Insurance Company before his retirement.

***McEwen, Kenneth W.**, died Feb. 22, at the age of 59. He was chief-of-staff at Westlake Community Hospital in Melrose Park and a senior staff member at Oak Park Hospital.

Mendizabal, Frank, Chicago, died in January.

****Miller, Edwin M.**, Chicago, died Feb. 4, at the age of 83. He was a leading surgeon and professor of medicine in Chicago for 56 years and surgeon emeritus and professor emeritus at Rush Medical College.

Ricketts, Frederick J., San Diego, died Feb. 4, at the age of 59. He was a former practicing physician in Sadorus and member of the Campaign Medical Society.

***Serritella, Rocco V.**, Oak Park, died Feb. 24, at the age of 57. He was attending urologist at Cook County Hospital, where he also instructed interns.

***Sheinin, John J.**, Chicago, died Jan. 9, at the age of 72. He was former president of Chicago Medical School and known for his work in developing medical education throughout the nation.

Siler, Charles A., Oak Park, died Feb. 23, at the age of 88. He practiced in Oak Park for 40 years before his retirement.

***Standard, William P.**, Macomb, died in February at the age of 63. He was a past president of McDonough Medical Society.

***Starkman, Nathan M.**, Lincolnwood, died Feb. 28, while skiing in Colorado, at the age of 53.

***Tan, Yan Ping**, Oak Lawn, died Feb. 26, at the age of 43. He was a physician at the Stickney Township Memorial Health Center.

Weinstock, Emanuel, Chicago, died Feb. 22, at the age of 78. He was a retired oral surgeon.

***Wellstein, Anton W.**, Geneseo, died Feb. 7, at the age of 67. He was former president of the medical staff at Hammond-Henry District Hospital and mayor of Geneseo.

*Denotes member of ISMS

**Denotes member of 50-Year Club

U.S. cancer deaths by age

Currently there are about 22,000 cancer deaths annually of patients aged 15 to 44. Cancer is the leading cause of death among women aged 30 to 54. More than half of all cancer deaths last year were among persons over 65.

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®

(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male¹ and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

©1972 The Upjohn Company

Warnings: Antibiotics used to treat gonorrhea may mask delay the symptoms of incubating syphilis. Patients should carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia. During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin.

Trobicin®

sterile spectinomycin dihydrochloride
pentahydrate, Upjohn
single-dose intramuscular treatment

High cure rate: * 96% of 571 males, 95% of 294 females

(Dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

Assurance of a single-dose, physician-controlled treatment schedule

No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed

Active against most strains of *Neisseria gonorrhoeae* in vitro (M.I.C. 7.5-20 mcg/ml)

A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

*Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin medio in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluable and were not included.

JAT2 1848-6

globin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.

Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—single 4 gram dose (10 ml) intramuscularly.

How supplied: Vials, 2 and 4 grams—with ampoule of Bacterio-

satic Water for Injection with Benzyl Alcohol 0.9% w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

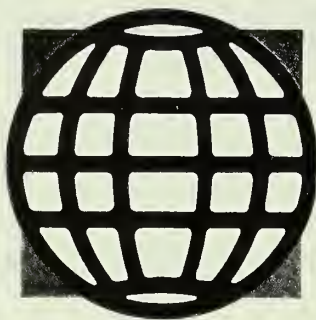
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

For additional product information, see your Upjohn representative or consult the package insert.

MED-B-1-S (LWB)

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001



socio-economic news

By JOSEPH J. LOTHARIUS

New HMO Guidelines Announced by IDPA

New HMO (Health Maintenance Organization) guidelines for any health delivery system desiring participation by the Illinois Department of Public Aid have been issued by Edward T. Weaver, IDPA Director. Weaver said HMOs wishing to contract with the state for rendering health care to public aid recipients must include: hospital services; professional services provided by practitioners under the Illinois Medical Practice Act, and prescribed drugs. In addition, the HMO must submit a plan for provision of mental health services currently provided by the Illinois Department of Mental Health. The HMO must also provide regular and periodic physical examinations including necessary diagnostic laboratory tests as specified by the primary physician. At the present time there are 27 HMOs in varying stages of development throughout Illinois. Of these, 16 are located in the Chicago area. The larger downstate HMOs are located in Cairo, Carbondale, Springfield and Lincoln.

ISMS Delegates Endorse HASP

The Hospital Admissions and Surveillance Program was formally endorsed by ISMS Delegates during the 1972 annual convention. Delegates strongly supported HASP as it is being implemented by the Illinois Foundation for Medical Care. Phase II of HASP began March 13 in several downstate hospitals in Region 4 (East St. Louis area). The program, which certifies length of hospital stays for Medicaid patients, began January 31 in seven large Chicago hospitals. Phase II target dates for implementing HASP in other regions were: Region 5—March 27; Region 3-B—March 20; Region 1-B—March 27; Region 2—April 3, Region 3-A—April 10, and Region 1-A—April 10.

IDPA pays MDs 79.8% Of the billed charges

Physicians were paid 79.8 percent of their billed charges by the Illinois Department of Public Aid during 1971. IDPA statistics for 1971 list payments to physicians totalling \$31,358,792 compared to charges of \$39,273,915. The 79.8 percent figure is an average percentage for the state. Individual percentages by county ranged from 96.8 percent in Hardin county to 73.8 percent in DuPage county. The Cook county figure was 79.6 percent.

3rd party payors may Be asked to release Fee profile data

A resolution approving the release of actual charge data and fee profiles from all third party payors to county medical society peer review committees and foundations for medical care was considered by ISMS' House of Delegates during the 1972 convention. The resolution stipulated that this information must be kept confidential and not released to other third party payors or governmental agencies. The matter was referred to the Board of Trustees for study and implementation. ISMS members should express their views on this issue to their District Trustee.

Soviet suspicion

In 1924, Dr. Alice Hamilton was invited to visit Russia to conduct a personal survey of that country's activities in industrial hygiene. The country had not as yet been recognized by the United States. It was a tense stay, for the period was still one of suspicion, suppression, and confiscation. . . . Some 23 years later, Dr. Hamilton commented on the gap in relationship between the United States and the Soviet, feeling that it was entirely possible to have two governmental formats coexisting. She saw danger in the Truman Doctrine, which meant to her that "we are ready to defend any government, no matter how rotten, provided it is anti-Soviet." She took Russia to task also, for defending any government, provided it was anti-capitalist. (Jean Spencer Felton.: Alice Hamilton, M.D.—A Century of Devotion to Humanity, *Jl. of Occupational Medicine* 14:2, Feb., 1972, pgs. 106-110.)

Filthy lucre—Dirty money?

Money is truly dirty—so say two monetary-minded physicians in the current Feb. 28 issue of the *Journal of the American Medical Association*.

The medical sleuths with numismatic leanings borrowed 62 pennies, 38 nickels, 27 dimes, 33 quarters and fifty paper bills of small denomination, with no discrimination as to age, sex, color or religion of the lender, so the results would be unbiased. They then cultured the coins and bills.

They discovered that 13% of the coins and 42% of the bills were contaminated by potentially disease-causing bacteria. Pennies, nickels and small denomination bills were more often contaminated than larger bills, a fact they explained was logically due to the rapid turnover and frequent exchange of small coins and bills.

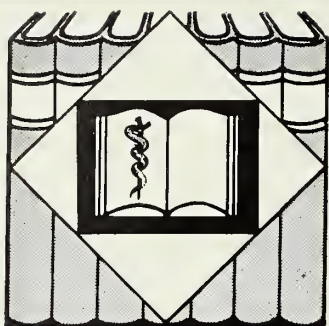
The investigators offered these tongue-in-cheek "Rules to Stay Sterile By:"

1. "Keep your money in the bank.
2. "If you must carry money, carry only large bills, preferably the \$50 and \$100 denominations.
3. "Don't make change.
4. "Keep your hands out of your pockets. (We have no suggestions as to where else you might keep them).
5. "Get rid of your money rapidly. (This isn't much of a problem for most of us).
6. "Campaign against piggy banks. (Particularly for children. They will be contaminated soon enough anyway.)"

Authors concluded sadly, "Despite the importance of this study, the investigators fear that people will continue to handle, fondle and jingle in their pockets—money."

As a panacea they suggested, "In order to further this research, we will accept and examine any money sent to us. If it is found to be contaminated, we have facilities for its safe disposal."

Authors are Drs. Berel L. Abrams and Norton G. Waterman from the Department of Surgery, University of Louisville School of Medicine, Health Sciences Center, Louisville.



the doctors library

The Dying Patient. By Russell Sage Foundation. Edited by: Orville G. Brim, Jr., Howard E. Freeman, Sol Levine and Norman A. Scotch.

Technology has enabled us to prolong life, almost indefinitely, but not necessarily human life, and as permissiveness has developed in questioning and criticizing cultural and civilized values, together man has been dehumanized. Throughout the book the message becomes clear that we cannot have two standards of morals in dealing with either the alive or dying patient. One standard based on the sanctity of human life, with emphasis on dignity and respect, and another based on standards of convenience and expediency, and yet remain civilized.

For all those sociologists, scientists and philosophers who concern themselves with absolutes, it is believed that this book represents a significant contribution to our understanding of dying and death.

The book is divided into three important sections. The first section concerns itself with philosophical and historical beliefs related to the social context of dying. The introduction is replete with profound questions and indeed, there are many answers to be found in the 14 contributions. Questions that are discussed include the actual process of dying, the heroic measures that are involved in maintaining life, the important question of whether one is prolonging life or prolonging the dying process; the question of euthanasia, and the rights of individuals to their privacy are at least presented.

The initial three chapters merely set the background for the principal feature of the second section which deals with the medical and hospital management of the dying patient.

One should single out as particularly excellent the discussions on "Innovations and Heroic Acts in Prolonging Life," "Patterns of Dying," and above all the chapter by Dr. Ross on "The Dying Patient's Point of View."

Interesting thoughts are presented in the chapter on "Dying in a Public Hospital." This is a provocative chapter by Sudnow. However, one has the feeling that he has a very biased viewpoint, and indeed a very limited one.

Sudnow does, however, make one interesting observation, that there is such a feature as social dying. However, there continues to be a thread of superficiality or perhaps of excessive speculation throughout what otherwise might have been an excellent contribution.

The chapters relating to the non-medical aspects of the termination of life, especially the social problems, and the legal ones are all excellent. In this context, it might be added that the State of Kansas has been virtually the first to re-define death, and indicate in two sets of circumstances, that death is a diagnosis and basically the responsibility of the physician.

The reader will be challenged by many of the statements. One especially must be frightened of the frequent allusion to the concept that a physician or a committee should have the prerogative under certain social circumstances, for supposed reasons of eugenics or of economic and population problems, that the physician should be permitted to positively end a life.

It has not been too clearly stated, but it is implied, and should be explicit that terminating extraordinary medical care in hopeless and irreversible states is not a positive act of terminating life, and is therefore not euthanasia. It should be clearly understood that such a rational approach represents acts permitting death.

This is a book which shows that death, like many other aspects of life, must be brought out into the open, and discussed without fear or without abhorrence. Although there is some overlapping, the repetition is salutary. In general, although styles differ somewhat they are all interesting and informative. It is recommended reading for all those who deal in acute medical

care, whether they be physicians in Intensive Care areas in hospitals, those who concern themselves with trauma, as well as those people who are on the periphery of the dying patient, including friends, the legal profession and society as a whole.

Vincent J. Collins, M.D.

The Complete Allergy Guide. By Howard G. Rapaport, M.D., and Shirley Motter Linde, M.S., 1970, Simon and Shuster, New York, p. 447.

While Shirley Motter Linde was with us in Chicago, she steadily contributed to the work of the American Medical Writers Association and to its greater Chicago Chapter along with her professional assignments at the Northwestern University Medical School. After leaving us, she joined with Dr. Rapaport, a former president of the American College of Allergists, to prepare **THE COMPLETE ALLERGY GUIDE**. As a capable writer and also as a sufferer from allergic disorders herself, she was able to help Dr. Rapaport put together a book, designed as they say, so that "Physicians will find the book broad enough in scope and filled with enough practical details that they—no matter whether allergists, general prac-

tioners, internists, psychiatrists, or pediatricians—will be able to use it in their practices as a means of instructing their allergy patients."

I was astonished to find how well questions that patients ask about allergy were anticipated by the authors. Hay fever, asthma, emphysema, eczema, hives, and a great variety of intestinal disturbances are considered along with provocative sources, whether from inhalents, foods, drugs, insects, plants, heat, cold or light. One of my consultants approached the book with serious misgivings when I asked him to evaluate the book's accuracy but he concluded: "The average allergic patient would have a better understanding of his condition after reading this book. . . . The errors . . . are mostly of a minor variety that could be found in any book."

Dr. Rapaport and Mrs. Linde prepare the patient for a trip to the allergist by asking him to come with a specific and objective analysis of his own problem. So prepared, he should be less apprehensive, more cooperative, and better able to cooperate with the physician. The book should also simplify the physician's chore, a simplification for which each of us can always be thankful.

William H. Wehrmacher, M.D.

Need information? Think of your library!

National Library Week (April 16-22) is greeted by the library profession with unbridled professional dedication and exhilaration—something like a doctor's anticipation of an AMA convention in Las Vegas. But exactly what does National Library Week mean to you?

It means that "You've Got a Right to Read" as the national slogans tout, and a right of access to the materials you need. In Illinois the hot library news is that, first of all, reference service is as close as the telephone on your desk (regardless of the size of your local public library). If you want to read recent research in your specialty, your library can furnish you with it. Through Illinois' network of 18 library systems, small libraries are able to function as large ones in getting the professional materials you

desire through teletype hookups with major resource libraries in the state and nation. Printouts of journal and magazine articles are available as well as those hard-to-get volumes you need periodically.

In addition, your public library gives you the opportunity to expand and diversify your reading in other specialties and in non-technical areas. In addition you may borrow art prints on free loan for your home or office, and recordings and cassettes, and 16 mm. films.

Don't let your professional book and journal buying wipe out your pocketbook as quickly as a trip to Las Vegas might. If you haven't traveled to the public library recently, discover how it can provide you with your reading and research needs all year round.

"Illinois should have an Auxiliary..."

BY ADELE KWEDER

History

"ALL ABOARD," called the conductor as he swung his lantern announcing the departure of the Chicago-bound train. Dr. and Mrs. Henry G. Mundt settled back in their seats and discussed the events of the A.M.A. convention they had just left. Dr. Camp entered their parlor car and soon all three were engrossed in conversation about the Woman's Auxiliary. None of them had been previously aware that doctors' wives from 22 states had united to assist the medical profession in legislative and educational programs.

"Illinois should have an auxiliary," they agreed, and the wheels of ordination began to whirl.

On May 31, 1927 the House of Delegates at the 77th Annual meeting of the ISMS endorsed the organization of the Woman's Auxiliary to the Illinois State Medical Society. The first formal meeting of Illinois doctors' wives and women physicians was held in Moline in June, 1927. Mrs. G. Henry Mundt was elected to serve as the first president of the new organization, the purposes of which were to encourage legislation that would be beneficial to public welfare and against the handicapping laws which were being pushed; to have a wholesome and educative effect upon the public for the aims and ideals of the medical profession; and to establish a better understanding between the medical profession and the general public.

The foot was in the door of socialized medicine. Now the doctors had help to try to remove that foot. The medical society had openly stated that "through this auxiliary leverage can be brought to bear to secure legislation that will be beneficial to public welfare." They soon discovered that the same leverage could defeat legislation as well. Our doctors' wives united and so strongly and actively protested against the Sheppard-Towner Bill that Illinois defeated that bill. They protested the Newton Bill and the Anti-Vivisection law, and took an active part in discouraging the Wagner-Murray-Dingall Bill, a national health program which died in committee in 1943.

Those early successes created an impetus that has never slackened. We have "clout" because we work constantly, constructively and effectively with our doctors to pass legislation that is designed to improve public health. We keep our members informed about pending bills that affect medicine, we have encouraged them to get involved in political campaigns, and taught them how to work to get the candidate of their choice elected into office. We are urging them to join the Illinois Medical Political Action Committee so in unity as well as individually we can knowledgeably fight for what is good and right for our neighbors and ourselves.

This is only one of the many ways our 3000 members work together each year to truly attain the noble goals set by our founders so long ago on that whistle-tooting Illinois-bound train.

*ISMS Auxiliary
today, March, 1972*



Rx Product Index

<i>Albee/c-Donnatal</i> 315, 316 A. H. Robins Co., Inc.	<i>Orinase</i> 338-339 The Upjohn Company
<i>Dyazide</i> 352 Smith, Kline & French Laboratories	<i>Pfizerpen VK</i> 396-397 Pfizer Laboratories, Pfizer Inc.
<i>Empirin w/Codeine</i> 2nd Cover Burroughs Wellcome & Co.	<i>Premarin</i> 336-337 Ayerst Laboratories Div. American Home Products, Inc.
<i>Hydergine</i> 340-341 Sandoz Pharmaceuticals	<i>Tepanil/Quinamm</i> 407, 408 Merrell-National Laboratories
<i>Hydrodiuril</i> 333, 334 Merck Sharp & Dohme	<i>Trobicin</i> 410-411 The Upjohn Company
<i>Kinesed</i> 398-399 Stuart Pharmaceuticals Division of I.C.I. America, Inc.	<i>V-Cillin K, Pediatrics</i> 354 Eli Lilly & Co.
<i>Librium</i> 312-313 Roche Laboratories	<i>Valium</i> Back Cover Roche Laboratories
<i>Mylanta</i> 395 Stuart Pharmaceuticals Division of I.C.I. America, Inc.	<i>Vasodilan</i> 350-351 Mead Johnson & Co.
	<i>Versapen-K</i> 401 Bristol Laboratories

APPROVED

AVAILABLE NOW!

ISMS

MALPRACTICE INSURANCE

**Professional Liability Insurance
Program**

**Approved for Members
REGARDLESS of AGE
or SPECIALTY**

Protect Doctor's Integrity

Company will settle no claims without insured member's approval. Nuisance claims will be fought.

Improve Legal Climate

Company will retain outstanding defense counsels who are experts in professional-liability cases.

Provide Market Stability

Company will maintain an available market. Participation by the members is needed to assure this market.

Keep Members Informed

Company will tell members how to prevent claims . . . keep them aware of latest legal developments in malpractice field.

ISMS Supervision And Control

Premiums to reflect only the loss experience of ISMS. All questionable underwriting cases to be reviewed by ISMS. A UNIQUE FEATURE

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT ADMINISTRATORS:

PARKER, ALESHAIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

what goes on

a guide to continuing education

April 18-21—Duke University Medical Center

"The Fourth Annual Duke Physician's Assistant Conference"

The objective of this conference is to review the developments of interest to potential physician employers, program administrators and educators, and health researchers.

Fee: Preregistered \$70. AAPA Members \$70. Late registration after (April 10) \$75. Send to: The Fourth Annual Physician's Assistant Conference, Attn: Mrs. Bellinger, Dept. of Community Health Science, Box 2914 Duke Medical Center, Durham, North Carolina 27710.

April 18—Chicago Committee on Trauma of the American College of Surgeons

"General Surgery Trauma"

West Suburban Hospital, 518 N. Austin, Oak Park

April 26-27—The Cleveland Clinic Educational Foundation

"New Concepts and Practices in Diseases of the Colon and Rectum"

Cleveland Clinic Educational Foundation, Ohio

April 27-28—Illinois Heart Association

"Electrophysiology and Electrocardiology"

Holiday Inn East, Springfield, Illinois

May 1-3—American College of Sports Medicine

"How-To"

Tentative program includes symposia papers on wrestling, the precollege athlete, perceived exertion during muscular work, and "How-To" sessions on the following topics: Prescription for exercise; Examinations for inequalities of strength; Preventative care of the feet; Relating to the neurotically inclined athlete; Use of game films for obtaining history of injury; and Legal aspects of sports.

For additional information contact: Donald E. Herrmann, Exec. Secretary, American College of Sports Medicine, 1440 Monroe Street, Madison, Wisconsin 53706.

Philadelphia, Pennsylvania

May 1-3—National Safety Council

"Patient Safety and Preventive Medicine as it Applies to Safety"

Speakers on the various panels will deal with the application of the Occupational Safety and Health Act in the field of hospital safety.

Pre-registration will end March 30, 1972. Total cost of the seminar, including breakfasts and a dinner banquet, is \$25.00 per registrant.

Stouffer's Inn—Indianapolis, Indiana

May 1-4—The American College of Obstetricians and Gynecologists

"Health Care Delivery"

Meeting will have theme session each day and nine conferences related to day's theme. Themes are: What Do Women Want in Health Care?; Proposed Changes for Health Care Delivery; and Education for the Changing Practice of Obstetrics and Gynecology.

A variety of obstetric-gynecologic topics will be covered in concurrent correlated seminars, reports on clinical investigations and at breakfast and luncheon conferences. There will be daily presentations in the specialty divisions of Community Health; Endocrinology and Fertility; Fetal and Perinatal Medicine; Oncology; Pediatrics and Adolescent Gynecology; and Psychosomatic Obstetrics and Gynecology. Registration for nonmembers, \$75.

Contact: Donald F. Richardson, American College of Gynecologists, 79 W. Monroe, Chicago, Illinois 60603.

Conrad Hilton Hotel, Chicago

May 5-6—Kramer Foundation

"The Therapeutic Community: From Theory to Practice"

This Institute is planned for those who want consultation in a team setting with demonstration of therapeutic community concepts in action—educational programs, reality re-orientation, patient-family interviews, and community meetings. Those participants who wish to work on building the therapeutic com-

ponents in their own institutions will have an opportunity to participate in a team consultation with the Kramer Foundation staff led by Charles H. Kramer, M.D., psychiatric consultant to the Kramer Foundation and director, The Family Institute of Chicago.

For ten years the Kramer Foundation has been actively engaged in applying the concept of the "therapeutic community" to the care of the chronically ill institutionalized older patient. This Institute is open to those who work with patients either as staff or consultants. Registration is open with a \$75 fee for the first registrant from each institution and \$60 for each additional registrant from the same institution.

For further information write Dr. Leon Schwartz, coordinator, Kramer Foundation, 2 W. Johnson St., Palatine, Ill. 60067.

May 11—Chicago Committee on Trauma of the American College of Surgeons
"Musculo-Skeletal Trauma"

Michael Reese Hospital, 2929 S. Ellis, Chicago

May 11-13—University of Wisconsin
"Applied Genetics for the Clinician Conference."

The conference will include discussion and demonstration of: Basic genetic principles for the clinician; Foundations of Genetic Counseling; Newer methodologies and applications of cytogenetics; Prenatal genetics an *in vitro* assays of mutations in human cells; Transplantation Genetics; and Current and future possibilities of genetic intervention.

Contact: Dr. Fritz A. Bach, Associate Professor of Medicine Genetics, 418 Genetics, The University of Wisconsin, Madison, Wis. 53706.

May 15-16—The Committee on Adult Education of the American Academy of Orthopaedic Surgeons
"Postgraduate Course on Surgery of the Adult Foot"

Designed for orthopaedic surgeons and other interested physicians and allied health personnel, the course will cover a variety of topics including biomechanics of gait, spastic deformities of the foot-ankle, management of trauma, solution to common surgical and non-surgical problems as well as an in depth discussion on the selection of the level of amputation. Also featured will be three symposia dealing with ankle and foot injuries, prosthetic and orthotic needs of foot and ankle and neurovascular influences on wound healing.

For application forms and further information, contact Paul R. Meyer, Jr., M.D., 737 N. Michigan Ave., Chicago, Ill. 60611 or the American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago 60611.

Sheraton-Chicago Hotel, Chicago

May 15-20—American College of Surgeons
"Treatment of the Seriously Injured or Ill in the Emergency Room"

Trauma, acute medical problems, psychiatric problems and pediatric problems will be discussed. Registration will vary between \$50-75 for the first of the proposed 13 courses to be presented across the nation. Each course is approved for credit by the AMA toward its Physician's Recognition Award.

(See "What goes on" in the coming months for the dates and sites of other courses on this subject.) Contact: Trauma Division, American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611.
Jacksonville, Fla.

May 19—University of Cincinnati College of Medicine

"Organic Brain Disease & Pathologic Speech"

This program will include material concerning the patient with cerebral vascular accident and other central nervous system diseases. Fee: \$20.00 (Includes lunch). Medical students—free if space is available in auditorium. Limited registration. Please contact: Office of CONMED, Room 114 Medical College Bldg., Eden & Bethesda Avenues, Cincinnati, Ohio 45219.

May 22-25—International Childbirth Education Association

"This Child: The Quality of Life"

Subjects to be covered at the convention include: early family behaviour, development of the infant personality, breastfeeding, family centered maternity care, new developments in childbirth education, infant outcome and maternal medication, nutrition, and parent effectiveness training.

Non-ICEA members can register for the convention. Information and registration materials are available by writing to ICEA Convention, 11420 W. Belmar Dr., Hales Corners, Wis. 53130.

Pfister Hotel, Milwaukee, Wisconsin

May 24—Illinois Masonic Medical Center
"Precancerous and Potentially Malignant Oral Lesions"

Contact: Illinois Masonic Medical Center, Dept. of Dentistry, Section on Continuing Education, 923 W. Wellington, Chicago, Ill. 60657.

May 25—University of Cincinnati College of Medicine

"Current Concepts in Endocrinology"

Fee: \$20 (Includes lunch). Please contact: Office of CONMED, Room 114 Medical College Bldg, Eden & Bethesda Avenues, Cincinnati, Ohio 45219.

May 25-27—The Illinois Society of Anesthesiologists

"Regional Anesthesia"

Conrad Hilton Hotel, Chicago

(Save for reference)



Forest Hospital

announces the opening of a
Sexual Dysfunction Clinic

The Clinic is under the direction of Leo Jacobs, M.D., psychiatrist, and Jack Davis, M.D., obstetrician-gynecologist. It provides diagnostic and therapeutic services for couples who are experiencing significant and ingrained difficulties in their sexual functioning.

The Clinic's treatment teams include male and female therapists.

Referrals from physicians, clergy, and mental health professionals are accepted, as are self-referrals.

For further information call:
 (312) 827-8811 ext. 224

Forest Hospital
 555 Wilson Lane
 Des Plaines, Illinois 60016

COOK COUNTY
Graduate School of Medicine

CONTINUING EDUCATION COURSES
 STARTING DATES—1972

SPECIALTY REVIEW COURSE IN DERMATOLOGY, May 8
 SPECIALTY REVIEW COURSE IN OB-GYN, May 8
 SPECIALTY REVIEW COURSE IN MEDICINE, May 22, June 5
 SPECIALTY REVIEW COURSE IN RADIATION SCIENCE, May 22
 SPECIALTY REVIEW COURSE IN SURGERY, Part I, August 7
 SPECIALTY REVIEW COURSE IN ORTHOPAEDICS, September 11
 BLOOD VESSEL SURGERY, One Week, May 1
 ADVANCES IN SURGERY, One Week, May 8
 SURGERY OF TRAUMA, Four Days, May 15
 ADVANCED PERIPHERAL VASCULAR SURGERY, One Week, July 17
 INTERMEDIATE E.C.G., Two Days, May 11
 ADVANCED CARDIOLOGY, One Week, May 15
 RECENT ADVANCES IN NEUROSCIENCES, Two Days, June 1
 NEUROMUSCULAR LEARNING DISORDERS IN CHILDREN, June 12
 RHEUMATOLOGY REVIEW, One Week, June 26
 PULMONARY FUNCTION TESTS, Three Days, July 12
 ADVANCES IN MEDICINE, One Week, May 8
 FAMILY PRACTICE REVIEW, One Week, May 8
 BASIC DERMATOLOGY, One Week, May 1

Information concerning numerous other continuation courses available upon request.

Address:

REGISTRAR, 707 South Wood Street,
 Chicago, Illinois 60612



**GIVE
 THE WORLD
 A HELPING
 HAND.
 MAIL YOUR CHECK.**



CARE - NEW YORK, N.Y. 10016 OR AREA OFFICES

FOR SALE, LEASE OR RENT

FOR SALE: OAK PARK, ILLINOIS, MODERN BRICK MEDICAL OFFICE BUILDING, 2,500. sq. ft. with full basement. 50 x 125 parking lot adjacent. Layout will accommodate 3 or 4 doctors. Lab, X-ray and dark room. Centrally air conditioned. For details phone agent: (312) 386-1855.

SPACE AVAILABLE—Uptown professional building, 1038 W. Wilson Avenue, Chicago, Illinois. Inquire: **WORSKILL PHARMACY** on premises or Agent (312) 321-9380.

GENERAL PRACTICE for sale. Desirable Chicago suburb. Excellent 450-bed hospital, 2 blks from office. Over \$60,000 net. Call (312) 834-6084.

OFFICE SPACE in excellent location available for General Practitioner or Specialist. Call (312) 746-2046—Zion, Illinois.

MEDICAL BUILDING—RIVERSIDE, ILLINOIS . . . outstanding opportunity for professional man starting his practice or planning a relocation of his practice. Authentic Colonial Williamsburg design with two stories. First floor; 3 professional offices. . . . Second floor 2 deluxe apartments. Gross income exceeds \$18,000 producing completely sheltered 13% return on investment. Ideal for user or investor. Contact Tom McWilliams at (312) 354-9250.

OFFICE SPACE AVAILABLE in Modern Multi-Suite Professional Building located in the center of the Village of Mount Prospect just 3 blocks from the Northwestern Railroad Station and equipped with gas heat and central air-conditioning—1 reception room, Nurses Station, 1 doctor's office, 3 examining rooms—\$425.00 per month—Call Mr. Ball, 381-8990.

ATTRACTIVE OFFICE SPACE available in the **MEDICAL CENTER**, Oak Park Arms Hotel. Reception Room, Personalized Switchboard Coverage 9:00 A.M.-9:00 P.M., Drug Store, Adjacent parking. Please contact Robert Soulman—386-4040.

Classified Advertising Rates

30 words or less—	1 insertion	\$ 5.00
	3 insertions	\$12.00
	6 insertions	\$18.00
	12 insertions	\$30.00
30 to 50 words—	1 insertion	\$ 8.00
	3 insertions	\$14.00
	6 insertions	\$24.00
	12 insertions	\$40.00

A charge of 25¢ is made if replies are sent to a box number in care of the journal.

Cash with order. No general advertising accepted in classified column.

All copy must be typewritten on letterhead or business stationery of the advertiser. Instructions must state number of insertions, including time of first insertion. In the absence of this information, advertisements will be billed at the time of the first insertion, (when the ad appears for the first time).

Deadline for classified copy is the 20th of month preceding publication date.

Abdominal trauma

(Continued from page 378)

References

1. Freeark, Robert J., Love, Leon, Baker, Robert J.: "An active diagnostic approach to blunt abdominal trauma," *Surg. Clin. N. Amer.*, 48:97-109, February, 1968.
2. Tank, E. S., Eraklis, A. J., Gross, R. E.: "Blunt abdominal trauma in infancy and childhood," *J. Trauma*, 8:439-448, 1968.
3. Touloukian, Robert J.: "Abdominal trauma in childhood," *Surg. Gynec. Obstet.*, 127:561-568, September, 1968.
4. Welch, Kenneth J.: "Traumatic lesions of the abdomen," *Ped. Surg.*, 1:610, by Benson, et al, Chicago, Year Book Medical Publishers, 1962.
5. Bremer, E. H. and Dowli, A.: "Traumatic hemobilia: report of primary definitive treatment with right hepatic lobectomy," *Amer. Surg.*, 32:333-337, May, 1966.
6. Izant, R. J. and Drucker, W.: "Duodenal obstructions due to intramural hematoma in children," *J. Trauma*, 4:797, November, 1964.
7. Quinby, W. C.: "Fractures of the pelvis and associated injuries in children," *J. Pediat. Surg.*, 1:353-364, August, 1968.

ekg of the month

(Continued from page 366)

Answers:

A) 2,3 There is definite prolongation of the Q-T interval with a late occurring T wave. This late T wave could be mistaken for a U wave or a flutter wave. The ORS interval of 0.09 seconds is normal.

B) 2,4 This patient had taken an overdose of procaineamide, which has a quinidine-like effect. Toxicity of these drugs can be accompanied by prolongation of the P-R, QRS and/or Q-T intervals. If the Q-T interval increases by 25% or more in a patient receiving these drugs, toxicity can be assumed and the drug should be withdrawn.

Take stock in America
Buy U.S. Savings Bonds



your advertisers

Our Advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.

REGISTERED
AIA
MEDIA DATA FORM

CLASSIFIED ADVERTISING422-423

INSURANCE	Medical Protective	421
	Parker, Aleshire, & Co.	417, 421

PHARMACEUTICALS	Ayerst Laboratories Div., American Home Products, Inc.	
	<i>Premarin</i>	336-337
	Bristol Laboratories	
	<i>Versapen K</i>	401
	Burroughs Wellcome & Co.	
	<i>Empirin w/Codeine</i>	2nd Cover
	Eli Lilly and Company	
	<i>V-Cillin K, Pediatric</i>	354
	Mead Johnson Laboratories	
	<i>Vasodilan</i>	350-351
	Merck Sharp & Dohme	
	<i>Hydrodiuril</i>	333, 334
	Merrell-National Laboratories	
	<i>Tepanil/Quinamm</i>	407, 408
	Pfizer Laboratories, Pfizer Inc.	
	<i>Pfizerpen VK</i>	396-397
	A. H. Robins Co.	
	<i>Albee w/c & Donnatal</i>	345, 346
	Roche Laboratories	
	<i>Librium</i>	342-343
	<i>Valium</i>	Back Cover
	Sandoz Pharmaceuticals	
	<i>Hydergine</i>	340-341
Smith Kline & French Laboratories		
<i>Dyazide</i>	352	
Stuart Pharmaceutical Div., Division of I.C.I. America Inc.		
<i>Mylanta</i>	395	
<i>Kinesed</i>	398-399	
The Upjohn Company		
<i>Orinase</i>	338-339	
<i>Trobicin</i>	410-411	

SERVICES & CONTINUING EDUCATION	Blue Cross/Blue Shield	331, 332
	Cook County Graduate School of Medicine	420
	Pharmaceutical Manufacturers Association	347-349
	Forest Hospital	420

BLUE SHIELD REPORT





FOR *Illinois Physicians*

WE REQUEST YOUR ASSISTANCE . . .

Illinois Medical Service requests the assistance of all Illinois physicians in helping us to meet our responsibilities under Phase II of the Economic Stabilization Program. The Price Commission has issued certain guidelines which the health insurance industry must follow when making payments for medical services.

So that we can be sure the information we have on record is accurate and up-to-date, you may receive the following letter asking for information.

 BLUE CROSS  BLUE SHIELD	<div style="border-top: 1px solid black; border-bottom: 1px solid black; margin-bottom: 5px;"><small>PLAN FOR HOSPITAL CARE OF HOSPITAL SERVICE CORPORATION</small></div> <div style="border-bottom: 1px solid black;"><small>MEDICAL-SURGICAL PLAN OF ILLINOIS MEDICAL SERVICE</small></div>
<small>222 NORTH DEARBORN STREET, CHICAGO, ILLINOIS 60601 • 661-4200</small>	
Patient: Date of Service: Certificate No.: Service Rendered: Fee Charged:	
Dear Doctor:	
Thank you for the report of professional services to our member under our Blue Shield Usual and Customary fee program.	
A physician's Usual Fee as defined by the Illinois State Medical Society, is that fee usually charged for a given service by an individual physician to his private patient. Therefore, before this claim can be processed, we need the following additional information:	
1. If the fee charged in this case is your Usual Fee for the service, please give the date this fee was established. <div style="border-bottom: 1px solid black; width: 100%; margin-top: 5px;"></div>	
2. Is this fee in compliance with the current Federal Wage-Price Regulations? <div style="display: flex; justify-content: space-around; margin-top: 5px;">Yes ()No ()</div>	
3. Have you adjusted any other fees since 11/13/71? <div style="display: flex; justify-content: space-around; margin-top: 5px;">Yes ()No ()</div>	
4. If the fee charged in this case is not your usual fee, please describe any complications or unusual medical circumstances involved in this particular case that would reflect the charge reported. <div style="border-bottom: 1px solid black; width: 100%; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; width: 100%; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; width: 100%; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; width: 100%; margin-top: 5px;"></div>	
<div style="border-bottom: 1px solid black; width: 100%;"></div> <small>Signature of physician</small>	<div style="border-bottom: 1px solid black; width: 100%;"></div> <small>Date signed</small>
<small>Blue Shield Case Service Department</small>	
<small>05-153 4-72</small>	

Your assistance in returning this information to us promptly will aid us in processing your Blue Shield claim accurately and without unnecessary delays. Should you have any questions regarding this letter, contact your Professional Relations representative or the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601.

One of the Blue Shield's Professional Relations representatives may later contact you about the information you provided.

We thank you for your assistance in helping us to serve you and our Blue Shield members more efficiently.

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Clarification Of Some Entries On The Explanation Of Medicare Benefits Form

The Bureau of Health Insurance of the Social Security Administration has specified a list of explanatory phrases to be used on the Explanation of Medicare Benefits (EOMB) in clarifying the charges allowed or disallowed. Some of these may cause difficulty in interpretation on the part of the physician or the beneficiary. One in particular, the phrase "Medicare does not pay for these services or supplies" or "These are services or supplies", has caused a great deal of confusion as it is used whenever medical services or supplies or both are disallowed.

Most of disallowances for which this phrase is used are related to office visits, nursing home visits, or hospital visits at a greater frequency or over a longer period than seems medically justified by the medical information which has been provided. Other disallowed medical services to which this phrase might apply include the over-frequent administration of Vitamin B-12 or the administration of other parenteral medications which do not appear to be commonly accepted as reasonable and necessary treatment for the diagnosis provided. This phrase may also be applied to a disallowed item of durable medical equipment when the item is not considered medically necessary for the treatment of the patient's condition.

Some physicians have expressed bewilderment at the breakdown of charges on the Explanation of Medicare Benefits into groupings different from those submitted on the Request for Medicare Payment form. This type of division would occur when some of the charges billed, particularly for daily medical visits, were disallowed. For example, a physician visited a patient daily over a 58 day stay which began September 1. Medical information submitted indicates that daily visits were necessary for the first 30 days and twice weekly visits were necessary for the next 28 days.

The EOMB would show an entry for the dates 9-1 to 9-30 with the allowed charges equal to the charges submitted (provided that the submitted charges do not exceed the reasonable charge for that service). The next entry for dates 10-1 to 10-26 would be for the twice weekly visits during the next 28 days. The charges submitted would be eight times the daily charge submitted (2 visits per week times 4 weeks or 28 days) and the charges allowed would be eight times the reasonable daily charge. The final entry for dates 10-2 to 10-28 would show the charges submitted for 20 days, zero for the

charges allowed, and "These are medical services or supplies" as the explanation for the disallowance. This entry refers to the complete disallowance of 20 of the hospital visits during the last 28 days of the stay, i.e., those visits over and above the twice weekly visits which had been determined to be medically reasonable and necessary from the medical evidence submitted.

Documenting Services Of An Attending Physician In A Teaching Institution

Part B Medicare can make payment for the services an attending physician (other than an intern or resident) provides to individual patients in a teaching setting. To qualify as an "attending physician", a teaching physician must, as a minimum, review the patient's history and physical examination, personally examine the patient within a reasonable period after admission, confirm or revise the diagnosis, determine the course of treatment to be followed, assure that any supervision needed by interns or residents is furnished, and make frequent review of the patient's progress.

Documentation that a covered service was provided must be made in the patient's medical record. Notes signed or countersigned by the attending physician should indicate that he personally reviewed the patient's medical history, gave a physical examination, confirmed or revised the diagnosis, visited the patient during the more critical period of the illness, and discharged the patient. For all other individual occasions of service for which the attending physician bills, notes in the medical record by interns, residents, or nurses which indicate that the physician was physically present when the service was provided are sufficient documentation of the physician's involvement.

SSA Certifies New Laboratories

The following laboratories have been certified for Medicare participation by the Social Security Administration:

Clara Bruce, M.D. Laboratory
5679 West Madison Street
Room 202
Chicago, Illinois 60644

Garco Medical & X-Ray Laboratory, Inc.
933 West Belmont
Chicago, Illinois 60657



illinois medical journal

volume 141, number 5

May, 1972

staff	editor	Theodore R. Van Dellen, M.D.
	managing editor	Richard A. Ott
	assistant editor	Gerald A. Frankel
	advertising manager	John A. Kinney
	executive administrator	Roger N. White

convention summary	Abstracts of Board actions	447
	1972-73 Officers and Board of Trustees	482
	Highlights of Convention	483
	Summary of House of Delegates Actions	489
	Actions and Resolutions	492

clinical articles	Earlier and Better Eye Care for Our Children <i>Edward G. Fortier, M.D.</i>	455
	Skin Manifestations of Hypovitaminosis A <i>Tibor Benedek, M.D.</i>	460
	Bicycle Spoke Injuries <i>Harvey Kravitz</i>	464
	Maternal Death Study case report No. 3 <i>Robert E. Hartman, M.D.</i>	471
	Initial Care of the Critically Injured <i>Robert J. Lowe, M.D., Teresa L. Romano, B.S.N., David R. Boyd, M.D.C.M.</i>	474

special article	Chicago Symphony Orchestra—Touring Europe <i>Philip Kaplan, M.D.</i>	472
--------------------	---	-----

surgical grand rounds	Resection of Myocardial Infarct	467
--------------------------	---------------------------------------	-----

features	the presidents page	440
	the viewbox	459
	ekg of the month	463
	doctors library	479
	new pharmaceutical specialties	480
	editorials	494
	practice management	498
	obituaries	499
	pulse of the doctor's wife	505
	what goes on	503
	clinics for handicapped children	510

(cover by Alicia Albanese)

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.



Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601. Copyright, 1972, The Illinois State Medical Society.

Subscription \$5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$7.50 per year for all foreign countries included in the Universal Postal Union. Canada \$5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

REGISTERED
AIA
MEDIA DATA FORM

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®

(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent, 4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male¹ and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

©1972 The Upjohn Company

Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia. During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemo-



PATIENTS CAN BE SUCCESSFULLY MAINTAINED ON A DRUG CONTAINING THYROXINE ALONE.

Thyroxine (T_4) is, as you know, the major circulating hormone produced by the thyroid gland. It is also produced, in smaller amounts, and is active at the cellular level. For years it has been a working hypothesis among endocrinologists that T_4 is converted by the body to T_3 . In 1970 this process, called "deiodination," was demonstrated by Braverman, Ingbar, and Sterling². T_4 does convert to T_3 , though the precise quantities are still being studied.

The conversion has been clinically demonstrated during the administration of T_4 to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, but the presence of T_3 in these patients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3 ?

Very simple. T_3 costs more to make synthetically than does T_4 . So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID³ because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyrotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

Synthroid[®]

(sodium levothyroxine)

THE FACTS ARE CLEAR AND HERE IS OUR OFFER.

FACTS:

Synthetic thyroid drugs are an improvement over animal gland products. Patients, even athyrotic ones, can be completely maintained on SYNTHROID (T_4) alone. Thyroid function tests are easy to interpret since they are predictably elevated when the patient adheres to SYNTHROID. Of all synthetic thyroid drugs, SYNTHROID is the most economical to the patient.

OFFER:

Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

Name _____

Address _____

City _____

State _____

Zip _____

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for Injection is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

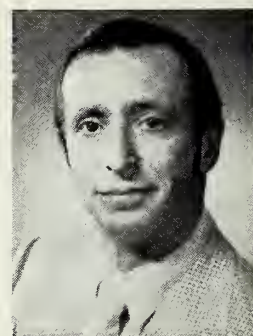
Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.



FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Morton Grove, Illinois 60053

the presidents page



He Who Stands and Waits

It's no secret that physicians, hospital administrators and hospital governing boards are frequently at odds over who should play lead trumpet in the health care delivery band.

Recently the American Hospital Association publicly challenged the AMA as to which organization is more logically equipped to effect changes in our health care delivery system. Then add the host of splinter groups which believe **THEY** should be playing lead trumpet and we don't hear any melody at all . . . just noise and flat notes.

It's true that most health care is dispensed in hospitals, but it's physicians who admit patients and physicians who dispense most of the care.

So it must be physicians who lead the way in preserving the best features of our present system while developing practical new approaches to health care delivery beneficial to patients, physicians and hospitals as well.

That's why it's so important that physicians be represented at meetings such as the two workshops held in Champaign and Chicago in April. Presented by the Joint Commission on Accreditation of Hospitals, the workshops covered new medical staff and hospital accreditation standards.

Standing-room-only crowds of 334 persons showed up at Champaign, and 461 hospital administrators, trustees and staff physicians at-

tended the Chicago workshop. At Champaign 61 medical directors and staff physicians were in attendance, while 121 attended the Chicago meeting.

The input that these physicians made is important. The workshops emphasized that physicians, administrators and hospital governing boards must impose certain voluntary controls over health care dispensed in the hospital, and show more concern over total health care as dispensed at the community level.

The medical profession must keep a close eye on the directions that such changes take, especially changes proposed in medical standards and staff accreditation.

And unless we physicians are willing to exercise leadership, then someone else will!

We must not allow ourselves to become so involved in our own practices that we abdicate our responsibility in preserving the private practice of medicine and what it means to us . . . and to our patients!

If we do abdicate this responsibility, we will become mere employees in health care delivery.

Don't **EVER** forget this: Those physicians who stand and wait do **NOT** serve the medical profession!

Frank J. Girke, M.D.

Abstracts of Board Actions

Board of Trustees Meeting

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

March 6-10, 1972

Chicago, Illinois

Board Recommends Dues Increase

The Board of Trustees voted to ask the House of Delegates to increase annual dues \$25 per member beginning in 1973. Having been notified by the Finance Committee in January that the Society could not continue to operate its current level of activity without more money, the Board informed all county societies and delegates to the 1972 House that it would request an increase. BY OFFICIAL ACTION of the House of Delegates, total ISMS dues for 1973 will be \$130, plus a \$1 assessment per full dues-paying member for services to students, and in-training members.

Student Membership

Following House action amending the Bylaws to allow individual medical students to become ISMS members for the first time, the Board voted to ask the House of Delegates to set \$10 as the annual dues for students and in-training physician members.

Continuing Education Council To Be Incorporated

BY OFFICIAL ACTION, the Board endorsed a plan for incorporating the Illinois Council on Continuing Medical Education, which was authorized by the 1971 House of Delegates. ISMS Trustees will serve as members of the corporation, which will have a Board of Directors composed of ISMS and medical school representatives.

Help For Mental Health Institutions

Dr. Albert Glass, Director of the Department of Mental Health, appeared before the Board to outline steps being taken by the Department to upgrade the requirements for physicians employed in the state hospitals. He requested assistance in establishing a formal program of consultation and peer review by local medical societies. The Board recommended that the new Illinois Council on Continuing Medical Education devise programs to help hospital-permit physicians pass medical licensing examinations. The appointment of an ad hoc committee composed of appropriate ISMS representatives was authorized to meet with officials of the Department of Mental Health to consider methods of assisting the Department.

Meeting With Specialty Groups

The Board approved an Executive Committee recommendation that a meeting of the presidents of all statewide specialty groups and the officers of ISMS be called to discuss ways of further coordinating programs.

Placement Service

The Board approved a recommendation from the Task Force on Physician Shortage that the ISMS Placement Service be reinforced by requiring communities seeking physicians to post a \$40 registration fee, which will allow the community to advertise in four issues of the Illinois Medical Journal and participate as an exhibitor in the next Doctor's Job Fair.

Chamber Of Commerce Membership Dropped

The Board voted to discontinue ISMS membership in the U.S. Chamber of Commerce, saving \$700 in annual dues.

Peer Review Manuals

In accordance with Board action, ISMS will purchase AMA Peer Review Manuals for distribution to District Peer Review Committees.

Dr. Dukes Recommended For State Advisory Committee

BY OFFICIAL ACTION, the Board recommended Dr. Richard E. Dukes, of Urbana, for appointment to the Health Education Advisory Committee being established in the Department of Public Instruction to assist in administration of the new Comprehensive Health Education Act.

Medical School Appropriations

Ratifying its position on restoring appropriations to medical schools in accordance with recommendations of the Health Education Commission of the Board of Higher Education, the Board voted to support appropriate legislation for the purpose. It was the sense of the Board that such legislation should emanate from the medical schools rather than from ISMS.

Three Legislative Bills Opposed

On recommendation of the Governmental Affairs Council, the Board voted to oppose the following legislation as presently written:

HB 3771—Physical Examinations for Professional Athletes

HB 3799—Temporary Licensure Status for Foreign Physicians

HB 3676—Amendments to Coroner Law without providing for medical examiner system

The Board approved a bill to create a medical examiner system as developed by ISMS and it expressed favor for passage of HB 3636 (pre-emptive licensure), but directed legal counsel to prepare a bill to exempt physicians and dentists from home rule licensing should HB 3636 fail.

It also reaffirmed its position on support for health care delivery of migratory workers.

Interagency Task Force On Manpower

BY OFFICIAL ACTION, the Board voted to request that notices and minutes of all meetings of the Interagency Task Force on Manpower be supplied to ISMS. The Board also requested that a plan be developed to gather regular reports from ISMS representatives from similar agencies.

Smallpox Vaccinations

The Board concurred with the recommendation of the chairman of the Council on Environmental and Community Health that compulsory smallpox immunization be removed from the statutes. The Board agreed that ISMS conduct an educational campaign on indications and contraindications for immunizing for all preventable diseases.



IMJ

Illinois Medical Journal

Vol. 141, No. 5, May, 1972

BY EDWARD G. FOTIER, M.D./LOMBARD

EARLIER AND BETTER EYE CARE FOR CHILDREN

Eventually, early eye examinations will be performed with the same reverence with which a child's heart, abdomen, teeth, and even umbilicus and rectum are examined today. In this 8 year analysis, 70% of the parents interviewed believed that the schools had "examined" their child's eyes. Only 0.9% (4/452) of such parents requested a routine professional eye examination for their child before school age, versus 19% (96/509) of parents who did not think the schools "examined" eyes. In the 6-8 year ages studied, only 24% of the children had ever received a professional eye examination (only 9% of these were by an ophthalmologist) despite the usual incidence of serious and potentially serious physical, refractive, and congenital abnormalities in this series. A concerted effort by educators is needed to encourage parents to seek for their children a meaningful professional eye examination at an earlier age.

Despite the supposed enlightenment of our present medical era, as yet not even the most rudimentary health advances have been applied to the care of children's eyes.

Military draft physical examination statistics have long shown that eye disabilities are more frequent than are disabilities of any other body organ among male youths reaching maturity. Statistics for maturing females, if available,

could hardly be expected to show any greater respectability because there has been no concerted effort by the medical or allied health professions to protect and preserve the sight of our young people.

Eventually, a routine eye examination will be performed on every child between the ages of one month to two years.

Effective minimal standards of eye care must be established, and

the combined efforts of physicians, health authorities, and all other educators will be needed to quickly implement these standards on the parental level.

A broad awakening to the many things that are wrong with our present system of providing eye care is the first step. People generally, and young parents in particular, are confused about just what constitutes a professional eye

examination, and they are not sure where such examinations are conducted, or at what age it might be best to secure such an examination for their children.

Purpose

The purpose of this paper is to organize, explore, enumerate and publicize various parental misconceptions and erroneous rationalizations about eye care, in order to illustrate the immense problem of thought restructuring we face before the visual prospects of our young people can be improved.

The difficulty basically involves generating common-sense thinking based upon facts. However, because the various opposing misconceptions and rationalizations are so widely and so deeply ingrained into our society, the obstacles are formidable indeed.

In searching for an approach to these problems, this author concluded that there was much to be learned by a study of office patient records even though it is hard to organize such data for analysis. Several office record studies have been compiled in the past, but these studies have only included children referred because of a school screening program test or the like.

This paper is believed to be the first to study every child within a certain age group examined by one practitioner over a significant duration (8 years). In particular, every parental estimation or evaluation of any prior eye care which the child might have received was carefully recorded. Also, the various parental reasons for bringing each child to examination were compiled, as were the objective physical findings of each case.

One purpose of this study is to investigate the adequacy of parental claims that a child has previously undergone an eye examination. Each case where the parent had replied "Yes" to the question of a prior eye examination was audited to determine the type of

examination which had been performed (school screening, optometric, etc.) and to catalogue the particular reason, symptom or complaint which prompted the visit to this office. The results of this inquiry are summarized in Table 2.

A further purpose of this study is to try to begin to get some insight into the workings of the average parental mind when they are confronted by a child who, for example, is a poor student or has an obvious eye abnormality such as a pronounced inward turning of one or both eyes.

The description of where some of these parents go *first* for help with a variety of physical, refractive and congenital abnormalities suspected or discovered in their children is graphically presented in Table 3. Such information has never before been available and it is the hope of this author that this added insight will stimulate efforts by educators to encourage parents to seek for their children a meaningful professional eye examination at an increasingly earlier age.

Modus

In preparation for this study over the last several years, I have been recording on my clinical records each parent's answer to the basic question "*Has ever had his (or her) eyes examined before?*" The question was consistently phrased this way in order to encourage impersonal and objective responses as far as possible.

Each parental estimation of any prior eye care which the child might have received, and the particular reason for bringing each child to this office were routinely recorded. Also recorded was the entering best visual acuity, the date of the last eye examination, the refraction and the objective physical findings in each case.

Altogether, this data has been recorded on 1,444 new (to this office) patients between the ages

of birth through 8 years (Table I). These patient records have been permanently coded for ready identification so that they may be subjected to more detailed analysis if desired.

This particular study is confined to those 452 new patients in the 6-8 year age group whose parents replied "Yes" to the question of a prior eye examination.

Results

(A) Background and Identification

The background 1,444 children aged birth through 8 years old which were examined by me from January 1, 1964 to December 30, 1971, and the proper identification of the 452 children aged 6 through 8 years old involved in this study are presented in Table I.

From Table I it can be seen that at least 58 parents replied correctly that their children had *never* had an eye examination even though these same children had participated in a school or pre-school visual testing program.

Since these visual screening programs are now so widespread as to be almost routine, it must be recognized that a large number (if not almost all) of the other 451 "*never*" answering parents also answered correctly, because few of these children could have avoided participating in one or more such visual testing programs.

Most importantly, 19% (96/509) of the parents who did not think the schools "examined" eyes were stimulated to request a routine eye examination for their children, versus only 0.9% of parents who believed that the schools had examined their child's eyes. (Table 2) Percentage-wise, children of parents who do *not* think that schools examine eyes are twenty times (2000%) more likely to receive a medical eye examination before their ninth birthday than are children whose parents believe that schools *do* examine eyes.

Table I
Number of New (to this office) Patients
Aged Birth through 8 years
Examined during the 96 month period
1964-1971

1. Number of new patients aged birth through 5 years old	483
2. Number of new patients aged 6-8 years old whose parents said they <i>never</i> have had an eye examination before	
a. Routine eye examinations requested by the parents	96
b. Eye examinations requested by the schools	58
c. All other requests	355
Total	509
3. Number of new patients aged 6-8 years old whose parents said "Yes, they have had an eye examination previously"	452
Totals	1,444

(B) Source of the 452 "Yes" claimed Prior Eye Examinations

An introspective analysis of the actual prior status of the 452 children whose parents stated "Yes, they have been examined before" is presented in Table 2.

Table 2 shows that, in 70% (316/452) of the "Yes" answers, the parents were referring to a school screening test which their children had either passed or failed.

(C) Source of the 132 "Yes . . . another opinion" Answers

A qualitative analysis of the wide variety of conditions for which "another opinion" was requested, and the sources of the prior "examination" for each category are presented in Table 3.

Table 3 shows:

1. For children in the "poor reader" or "poor student" classifications, 100% (8/0) of the parents *first* sought out the opinion of an optometrist.

2. For children with mild to severe astigmatism or myopia, 80%

(32/40) of the parents *first* sought out the opinion of an optometrist, while 20% (8/40) first consulted an ophthalmologist.

3. For children who had an eye muscle-problem which was noticed during the first 12 months of life (congenital or infantile esotropia), 60% (6/10) of the parents *first* sought out the opinion of an optometrist, while 40% (4/10) originally consulted an ophthalmologist.

4. For children who had been examined elsewhere some time ago and who had suffered an injury to their eyes within the last 24

Table II
Analysis of 452 Children in the 6-8 year age group whose parents stated "Yes, my child's eyes have been examined before, but . . ."

A.	
—he failed the school eye examination and a further examination was advised."	238
B.	
—even though <i>he passed</i> the school eye examination, he still . . .	
1. —squints."	9
2. —complains that his eyes hurt; they tear constantly and he rubs them a lot."	3
3. —complains of headaches."	4
4. —complains that words in books are crooked."	1
5. —complains that he can't see the blackboard."	6
6. —complains that he can't see distance."	16
7. —reverses his letters."	4
8. —holds books too close."	7
9. —is a poor reader."	15
10. —is a poor student."	13
Total	78
C.	
—we would like to have another routine examination of his eyes	OD—2 OPH—2
Total	4
D.	
—even though he has been examined elsewhere, we want <i>another opinion</i> on his condition."	132
Totals	452

hours (trauma, recent), 3 parents first sought out the opinion of an optometrist, at which point they were referred to this office.

(D) Compilation of all 452 Examination Sources Which Comprise the "Yes" (They have been examined before) answers).

Number Percent

1. School Screenings	318	70%
2. Optometrists	71	15%
3. Ophthalmologists	42	9%
4. Ped. or FMD	5	1%
5. Unknown or NR	16	2%

Discussion

The purpose of this study is to point out the great confusions which exist in the parental mind

regarding proper eye care for their children, as a first step toward improving that care. That such a fabulous confusion exists today is fully demonstrated by the results I have extrapolated from my records. These results speak more eloquently for themselves than any discussion I could make. Why else, for example, among the 452 children in this study believed by their parents to have had an eye examination, should only 113 or 24% actually have had an ophthalmologic or optometric professional examination?

Or, why should 70% (316 out of 452) of the parents in this study say that their children have had an eye examination when, in fact,

they have only participated in a school vision survey?

Public Health officials and school authorities all are vociferous in their claims that parents are adequately and repeatedly informed that these so-called school tests do not constitute an eye examination. If my sampling of parental replies can be taken as representative, it is not possible for hundreds of thousands of parents living everywhere across the country to all be wrong, and only the very few health officers and educators to be right in this tenet. Before any real progress can be made, better answers to this dilemma, as well as the other dilemmas exposed in this study, must be found.

Table III

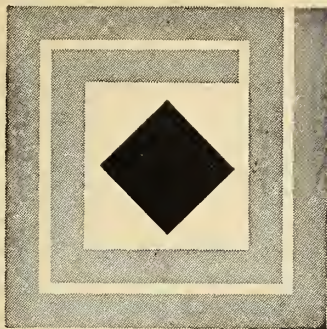
Analysis of 132 Children in the 6-8 year age group whose parents stated "Yes, my child's eyes have been examined elsewhere but we wanted another opinion on his condition"

1. Less than-3.50 Cylinder.
2. More than-3.50 Cylinder.
3. Less than-6.00 Sphere.
4. More than-6.00 Sphere.
5. Worst Eye: Best corrected vision better than 20/50.
6. Worst Eye: Best corrected vision worse than 20/50.
7. One child in this group had been seen by two optometrists, one at Sears and one in a newspaper advertising private practice partnership.
8. Inward turning noted at birth.
9. Inward turning noted during the first year of life.
10. Inward turning in a far sighted child with accommodative excess. Onset is typically after the second year of life.
11. Outward turning of one or both eyes which may or may not be noticed by the parents. Onset may be at any age but the tendency to this muscle imbalance can usually be detected by careful examination as early as the first or second year of life.
12. This patient claimed that she had her eyes examined "every year" in school prior to the onset of esotropia at an age of almost 9 years. A check with the school, however, disclosed that a muscle imbalance was present from the first, and a "further examination" was advised from the first.



Edward G. Fortier, M.D., graduated from Northwestern Medical School and interned at Cook County Hospital. After a residency at County, he practiced pediatrics for three years before entering on Ophthalmology residency at Hines VA Hospital. He has practiced ophthalmology in Lombard, Illinois for 15 years.

Reason for current Consultation	Origin of Previous Examination				
	Lions, PTA or School Screening	PED, FMD	OPH	O.D.	Unknown or NR
1. Infections	4	1	4	1	
2. Trauma, recent			3		
3. Lid droops	1	2			
4. Lid twitches		1			1
5. Granulated lids			1		
6. Film over one eye			1		1
7. EMH					1
8. Squints		2			
9. Vision defect related to premature birth			1	1	
10. Poor reader				6	
11. Poor student				2	
12. Distance bothers					
a) Mild astigmatism ¹				10	
b) Severe astigmatism ²				10	
c) Simple Myopia ³		6	8	5	
d) High myopia ⁴		2	4	3	
e) Mild amblyopia ⁵		4	1	1	
f) Severe amblyopia ⁶			1	57	1
13. Congenital esotropia ⁸				3	
14. Infantile esotropia ⁹			4	3	
15. Accomodative esotropia ¹⁰	112		7	5	1
16. Exotropia ¹¹		1	7	2	1



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This 52-year-old female entered the hospital complaining of pain in the right elbow of one year's duration. Physical examination of this patient made the clinical diagnosis quite obvious so that we will withhold this information at this time.

What's your diagnosis?

- (1) Giant cell tumor of the ulna
- (2) Osteolytic metastatic disease
- (3) Hyperparathyroidism
- (4) Rheumatoid Arthritis
- (5) Osteomyelitis



Fig. 1



Fig. 2

(Answer on page 506)

SKIN MANIFESTATIONS OF HYPOVITAMINOSIS A

Among the important vitamins in human metabolism, the role of Vitamin A is least known. The role of Vitamin C (scurvy) was at least empirically recognized over one hundred years ago in the English Navy. Szent-Gyorgyi isolated it from Hungarian paprika. The deleterious effect of the lack of Vitamin B in beri-beri was recognized due to the use of polished rice. Goldberger, in 1915, discovered the cause of pellagra due to false diet lacking niacin (nicotinic acid), which sent many sufferers to mental hospitals. Vitamin D is long known as essential in early childhood to prevent and remedy crippling rickets.

The Vitamins B, C and D had a common feature: their metabolic disturbances eminently interested the Public Health Service, and elicited early governmental investigations and interventions. Due to this central interest and pressure, scurvy, beri-beri and rickets have been practically eliminated.

This, however, is not the case concerning the metabolic disturbances of hypovitaminosis A. Since these manifestations do not involve public interest, the Public Health Service did not enter the field of investigation as did the British¹ and Canadian Public Health Services²⁻⁴. Thus, the whole question of hypovitaminosis A was completely neglected. Experimental investigations concerning Vitamin A metabolism in general are not lacking in animals (mice, rats, pigeons), but their results cannot be carried over to human conditions. Experimental investigations in humans, as British investigations revealed during World War II, are difficult.

Due to these facts, research in metabolism of Vitamin A in humans was lacking and the many

common skin manifestations of hypovitaminosis A remain unknown. The prevailing useless, ineffective, and often dangerous treatments represent a tremendous waste of money and time.

Clinic and Material of Acne Vulgaris

One of the commonest manifestations of hypovitaminosis A is acne vulgaris. It is characterized by three factors: follicular hyperkeratosis (comedo, blackheads); papules; and pustules. It often causes scarring. Even though its common localization is the face, upper part of the chest and the back, it may appear anywhere on the body. During World War II, in the Asiatic-Pacific Theatre, I observed the most unusual localizations. Lesions covered the whole buttocks, the abdomen, the upper and/or lower extremities, while the face often was not involved at all.⁵

The patients included in Table 1 were seen in my private practice. Without exception, they had long histories of acne and had been treated earlier with all the remedies on the books, with negative results.

Among the 183 patients, the initial blood level was determined in 100 instances. There were 36 males and 64 females. The average Vitamin A blood level was 52.4 ± 5.1 I.U., and among the females 54.1 ± 3.7 I.U. The average Vitamin A level of the entire group was 53.3 ± 3.7 I.U. The normal values are, according to Bodansky and Bodansky, 110 to 130 I.U. in the male, and 90 to 110 I.U. in the female.

Table 1

Distribution by age and sex of the patients **Vitamin A blood level determined (Initial blood level)**

Age	Female	Male	Total	
5-10	1	....	1	....
11-15	25	10	35	5
16-20	51	27	78	49
21-30	38	21	59	39
31-40	4	5	9	6
41-50	....	....	....	....
51-60	....	1	1	1
Total	119	64	183	100

Table I shows the amazing scattering of the Vitamin A blood level in acne patients. Only 22% of the patients showed Vitamin A levels above the critical level (70 I.U. in 100 ml blood) and the rest were far below. To correlate Vitamin A blood levels with skin manifestations of hypovitaminosis A and with the therapeutic effect of Vitamin A administration, the only effective method is the serial determination of Vitamin A blood levels before and during treatment.

Vitamin A Administration

Based upon my experimental studies,⁶ my standard oral dosage of Vitamin A is 200,000 I.U. daily. After extensive clinical experience of almost three decades, I consider this amount of Vitamin A as the optimal dose. However, the efficiency of orally administered Vitamin A in acne vulgaris has a definite limit. Failures reported in the literature may find an explanation in the assumption that oral administration of Vitamin A should have its full effect. Oral administration of Vitamin A is effective only in light cases of acne vulgaris with few comedones and/or pustules. This group includes adolescents who consistently exclude food items carrying Vitamin A sources (eggs, dairy products, liver, green and yellow leaf vegetables), or received false instructions from their doctors to avoid these foods.

Basically, Vitamin A is fully effective only by parenteral (intragluteal) administration in

avoiding the interference of the intestinal tract. The optimal parenteral dose of Vitamin A is 100,000 I.U. twice weekly. The amazing difference between the oral (1,400,000 I.U. weekly) and the parenteral dosage (only 200,000 I.U. weekly) points to totally unsolved problems in the metabolism of Vitamin A.

Will the intestinal wall absorb Vitamin A? If it is absorbed, will it not be properly utilized? Or will it be destroyed by an anti-Vitamin A which was postulated by the French investigator, H. Thiers?⁷ Only future and intensive research can answer these basic questions.

As I see it, it happened the first time that the optimal therapeutic dosage of Vitamin A in oral and parenteral administration in clinical, controlled experiments was established.

Prognosis

How long the only effective parenteral administration of Vitamin A is needed, one never can tell in advance. Table I reveals the extreme diversity of Vitamin A levels in acne patients. The body loses Vitamin A very slowly, but just so slowly goes its replacement. Without any local treatment, as the therapy progresses the pustules recede and disappear (they never should be touched by opening them), and the comedones spontaneously fall out and do not reform. It is naive to use any fancy instruments to "express" comedones, since they are not the cause, but the result of hypovitaminosis A.

Treatment should be carried on until all the clinical signs of acne have disappeared. Vitamin A blood levels should reach at least the critical level. How long the condition will remain healed and when there may be a recurrence, one cannot prophesy. After a fairly normal restoration of the vitamin A blood level, everything depends upon the subsequent vitamin A metabolism of the individual.

Discussion

In the last few decades a number of authors have reported favorable therapeutic results in acne vulgaris by oral administration between 40,000 to 150,000 I.U. Vitamin A. They saw some good results.⁸ Recently Plewig⁹ investigated the effect of topically applied Vitamin A acid. Contrary to expectations, however, that topically applied Vitamin A acid will inhibit keratinization (formation of comedones), the opposite occurred: the irritation caused by the drug led to an increased production of horny cells. I do not want to enumerate the endless flow of varied, local administration of chemicals, the

recent enthusiasm for tetracycline "therapy" with the sequel in a case of nephrogenic diabetes insipidus,¹⁰ or dietary measures which have no rhyme and reason based on the etiology and pathogenesis of acne. As to the dietary fad in acne vulgaris, I may quote Kligman¹¹ . . . "it is dastardly to deprive adolescents of chocolate, milk, nuts, sea food, etc., doctors interdict foods as a punishment!" I am completely in agreement with this statement and I let my patients eat everything without any "ontoward" effect. I would like to quote another passage from Kligman's article: "It is more helpful to say what acne is *not*—it is not due to external factors: diet, bugs, emotions, weather, etc. It is an endogenous disease. We are just beginning to understand acne."

Acne vulgaris, indeed, is an endogenous disease, one of the cutaneous expressions of hypovitaminosis A.

Hypervitaminosis A

The fear that the optimal dosage—oral and parenteral—of Vitamin A may cause the untoward effect of hypervitaminosis A is totally unfounded. Hypervitaminosis A was seen and reported in children and adults due to intake of enormous doses of Vitamin A without signs or symptoms of hypovitaminosis.¹²⁻¹⁴

References

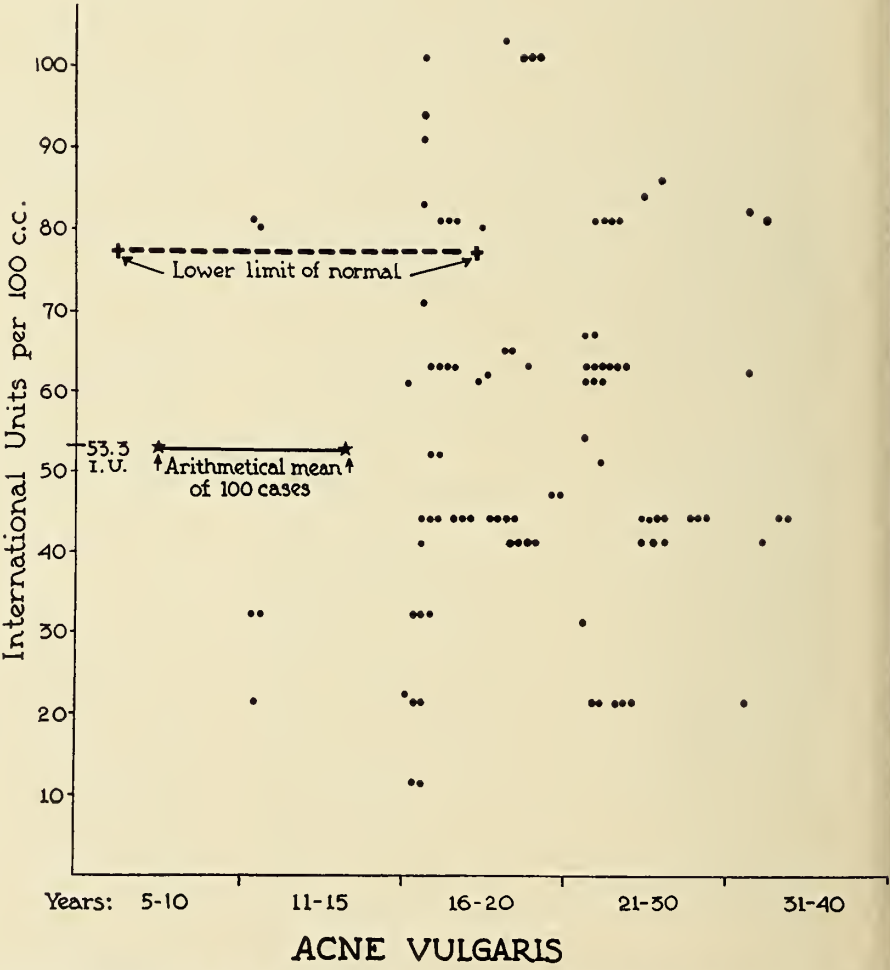
1. *Vitamin A requirement of human adults*. London, His Majesty's Stationery Office. Compiled by E. M. Hume and H. A. Rebs, 1949.
2. Hoppner, K. et al.: "Survey of liver Vitamin A stores in Canadians," *Canadian M.A.J.*, 99:983-986, 1968.
3. Hoppner, K. et al.: "Vitamin A reserves of Canadians," *Canadian M.A.J.*, 101:736-738, 1969.
4. Phillips, W. E. J. et al.: "Serum Vitamin A and carotenoids of Canadians," *Canadian M.A.J.*, 102:1085-1086, 1970.

(Continued on page 507)

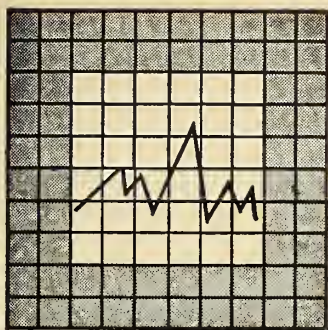
Tibor Benedek, M.D., is Associate Clinical Professor of Medicine (dermatology) at Stritch School of Medicine, Loyola University and chief of the Outpatient Clinic of Dermatology at Mercy Hospital Medical Center. He received an M.D. from the University of Budapest in 1911 and an M.D. from the University of Leipzig in 1922. He served his internship with the Army Hospital, Austro-Hungarian Army, 1916-1917 and residency at the Skin Clinic, University of Leipzig, 1920-1922.



He has been Editor-in-Chief, *Mycopathologia Applicata* since 1953.

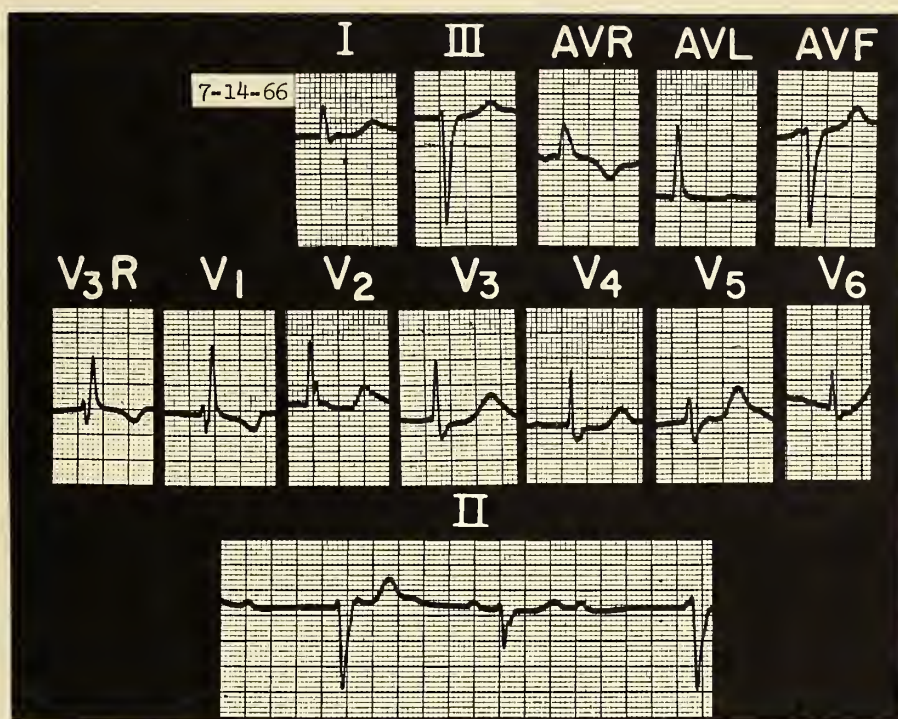


Distribution of the Vitamin A blood level according to age



ekg of the month

JOHN R. TOBIN, JR., M.D., M.S., RINGAUDAS NEMICKAS, M.D.,
PATRICK SCANLON, M.D., JOHN F. MORAN, M.D. AND JAMES
V. TALANO, M.D./SECTION OF CARDIOLOGY,
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This 72-year-old man was admitted to the hospital because of several recent bouts of syncope. He has no other complaints.

Physical examination is unremarkable except for a pulse rate of approximately 45/minute, intermittent cannon waves in the neck veins, and an S_1 of variable intensity.

QUESTIONS: (One or more of the choices may be correct.)

- A. The electrocardiogram reveals:
 1. There is left axis deviation.
 2. Conduction is normal.
 3. Right bundle branch block is present.
 4. There is a high degree of A-V block.
 5. There is probably Trifascicular block.
- B. The patients' syncope:
 1. Is unrelated to his heart.
 2. Is probably secondary to episodes of complete heart block.
 3. Should be treated with a pacemaker.
 4. Is benign so can be treated conservatively.
 5. None of the above.

(Continued on page 506)

Bicycle Spoke Injuries

A Report Of 64 Cases

The fact that bicycle riding can be dangerous is documented by a study of children admitted to two suburban hospitals for emergency treatment. This study reports on bicycle spoke injuries sustained by 64 children during the summer of 1971. The purpose of the investigation was to determine the frequency of bicycle spoke injuries, the types and causes of injuries and means by which they can be prevented.

Methods

Prior to the summer of 1971, the emergency rooms of Lutheran General Hospital, Park Ridge, Illinois* and Skokie Valley Hospital, Skokie, Illinois**, were alerted to watch for victims of bicycle spoke injuries. Emergency room reports were filled out for each bicycle spoke injury from June 1, 1971 through September 30, 1971. Data was collected on the age and sex of each child, the date and time of each accident, the type of bicycle, the manufacturer of the bicycle, the part of the body injured and the position of the rider on the bicycle when injured. Data was also obtained on the type of shoes the child was wearing at the time of the injury or whether he was barefoot.

Results

The types of physical injuries due to bicycle spoke injuries suffered by 64 children are summarized in Figure 1. Six fractures occurred; three involving the tibia and three the toes. There were 6 avulsions of the skin of the medial or lateral malleolus.

The most common injuries in our series were abrasions and contusions of the malleolus which occurred in 19 children. The second most frequent were contusions of the toes which occurred

in 9 of our cases. Figure 1 also summarizes the position of the rider at the time of the bicycle spoke injury. The largest number of reported accidents occurred when a single rider was on the bicycle. There were 21 accidents of this type. Second riders on carriers accounted for 9 accidents. Second riders on rear fenders and second riders on seats each added 11 accidents to the series. Second riders on the handle bars and crossbars of bicycles resulted in 4 and 8 injuries respectively.

Bicycle spoke injuries occurred in 59 children riding two wheelers while 5 children on tricycles sustained similar injuries.

Children riding bicycles sustained the most severe injuries. The six avulsion injuries and the six fractures reported in our study were seen exclusively in this group.

Children on tricycles sustained only minor abrasions and contusions of the ankle and foot.

Figure 1 also shows the relation of the type of injury to the position of the rider on the

*Department of Pediatrics, Lutheran General Hospital, Park Ridge, Illinois

**Department of Pediatrics, Skokie Valley Hospital, Skokie, Illinois.

Figure 1
Position of Child on Bicycle Compared to the Type of Injury
N = 64

Type of Injury	Single Rider	Second Rider Back Fender	Second Rider On Seat	Second Rider Handlebars	Second Rider Crossbar	Second Rider On Carrier	Total Injuries
Fracture Toe	1	1	1				3 (4.6%)
Fracture Tibia			1			2	3 (4.6%)
Avulsion Medial Malleolus		1	1		1	1	4 (6.2%)
Avulsion Lateral Malleolus				1	1		2 (3.1%)
Abrasion or Contusion Medial Malleolus	1	4	1		1	2	9 (14.0%)
Abrasion or Contusion Lateral Malleolus	1		3		4	2	10 (15.6%)
Laceration Medial Malleolus	2						2 (3.1%)
Laceration Lateral Malleolus	1						1 (1.5%)
Laceration Heel	2	3	2			1	8 (12.5%)
Abrasion or Contusion Heel	1			1			2 (3.1%)
Laceration Toe	4	2		1			7 (10.9%)
Abrasion or Contusion Toe	7		1			1	9 (14.0%)
Abrasion or Contusion Foot			1	1	1		3 (4.6%)
Laceration Foot	1						1 (1.5%)
Total Positions	21 (32.8%)	11 (17.1%)	11 (17.1%)	4 (6.2%)	8 (12.5%)	9 (14.0%)	64

bicycle. The most common injury for single riders was injury to the heel and toe. There was only one avulsion injury and one fracture in this group. Contusions and abrasions of the ankle were more common in second riders on the back fender.

There were two fractures sustained by second riders on bicycle seats. Seven of the nine injuries occurred to second riders while riding on banana seats. Abrasions and contusions of the ankle were common in this group. Only abrasions and contusions of a minor nature occurred in second

riders on handle bars. One avulsion injury to the ankle and abrasions and contusions to the ankle were found in second riders on crossbars. No fractures were noted in this group. Second riders on infant carriers sustained two fractures of the tibia, one avulsion injury and contusion of the ankle.

Injuries to the lower leg, ankle and foot almost always result from bicycle spoke injuries. Injuries to other parts of the body did not occur in this series.

Figure 2 shows the type of footwear worn by

Figure 2
Type of Footwear Compared to the Position of the Child
at the Time of the Bicycle Spoke Injury
N = 64

Type of Footwear	Single Rider	Second Rider Back Fender	Second Rider on Seat	Second Rider on Handlebar	Second Rider on Crossbar	Second Rider on Carrier	Not Known	Total
Barefoot	10	3	3	2	2	3		23 (35.9%)
Gym or Canvas Shoes	4	6	3	1	2	4		20 (31.2%)
Sandals	5	1	1	1	1			9 (14.0%)
Leather Oxfords	2	1			1			4 (6.2%)
Hush Puppies			1					1 (1.5%)
Mocassins					1			1 (1.5%)
House slippers					1			1 (1.5%)
Not Known							5	5 (7.8%)
Total Positions	21 (32.8%)	11 (17.1%)	8 (12.5%)	4 (6.2%)	8 (12.5%)	7 (10.9%)	5 (7.8%)	64

Figure 3
Type of Footwear Compared to the Type of Bicycle Spoke Injuries
in 60 of 64 Children

	Barefoot	Gym or Canvas Shoes	Sandals	Leather Oxfords	Hush Puppies	House Slippers	Moc- assins	Un- Known	Total Injuries
Fracture Toe	2		1						3 (4.6%)
Fracture Tibia	1	1			1				3 (4.6%)
Avulsion Medial Malleolus	1	2				1			4 (6.2%)
Avulsion Lateral Malleolus	2								2 (3.1%)
Abrasion or Contusion Medial Malleolus		7	1	1					9 (14.0%)
Abrasion or Contusion Lateral Malleolus	1	3	4				1		9 (14.0%)
Laceration Medial Malleolus				1					1 (1.5%)
Laceration Lateral Malleolus		1							1 (1.5%)
Laceration Heel	3	5							8 (12.5%)
Abrasion or Contusion Heel		1	1						2 (3.1%)
Laceration Toe	5			1					6 (9.3%)
Abrasion or Contusion Toe	6		2						8 (12.5%)
Abrasion or Contusion Foot	1				1				2 (3.1%)
Laceration Foot	1			1					2 (3.1%)
Unknown								5	5 (7.8%)
Total Footwear	23 (35.9%)	20 (31.2%)	9 (14.0%)	4 (6.2%)	1 (1.5%)	1 (1.5%)	1 (1.5%)	5 (7.8%)	64

64 children in our study. We found that 23 (35.9%) children were barefoot at the time of the accident. Gym shoes and canvas shoes were worn by 20 (31.2%). Twelve of the 21 who sustained bicycle spoke injuries while riding alone stated that their foot slipped off the pedal, resulting in loss of control of the bicycle and bicycle spoke injury.

Figure 3 shows the type of footwear compared to the types of injuries. Three of the six fractures in this series were found in the barefoot group. Laceration, contusion and abrasion of the heel and toe were present in 16 (25%) of the group). Injuries to the lateral and medial malleolus were highest in the group wearing canvas and gym shoes. There were 13 (19.5%) such injuries. There were too few children wearing sandals, oxfords, moccasin and hush puppies to note any specific type of injury.

The mean age of the children in our series was 6.8 years. There were 30 males and 34 females in this study. The sex difference is not significant. The bicycle accidents occurred between 10:00 A.M. and 9:00 P.M. with no significant large number of accidents at any of the daylight hours.

Discussion and Conclusions

If the 64 cases seen in two suburban hospitals were extrapolated for the 7,000 hospitals in the United States, we estimate over 225,000 bicycle spoke injuries each summer. This figure does not include the very large number of children seen in the practicing physician's offices. Each year we have seen between three to six such injuries in our offices who did not go to the emergency room prior to being seen.

The six fractures in our series serve to emphasize the seriousness of bicycle spoke injuries and the need to find means to prevent this type of injury. Drewes and Schulte¹ in a study of 212 children with bicycle spoke injuries found fracture of the foot and ankle in 9.43% of their cases. This compares closely with a 9.2% inci-

(Continued on page 509)

Harvey Kravitz, M.D. (right), is a pediatrician. A member of the National Accident Prevention Committee of the American Academy of Pediatrics and a member of the Child Health Committee of the Management National Safety Council, he received his M.D. from the University of Illinois.

Fredric D. Burg, M.D. is a former associate professor of pediatrics at Northwestern University Medical School, and formerly a staff member of Childrens Memorial Hospital.





surgical grand rounds

EDITED BY JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of March 2, 1971.

Resection of Myocardial Infarct

Case Report

Dr. Richard Geier: A 58-year-old white priest was well until January 20th when, while jogging early in the morning, he felt a severe ripping pain in the chest, which lasted several minutes and then disappeared. The next morning, while taking the commuter train to work, he again felt a sharp, sudden pain in the lower mid-chest, which persisted. He went to his doctor who examined him and ordered an electrocardiogram. The examination revealed no heart murmur; the cardiogram was abnormal, and the patient was hospitalized with the diagnosis of acute myocardial infarction. When he was examined the following morning, a loud systolic murmur was heard. After surgical consultation,

the patient was transferred to Chicago Wesley Memorial Hospital that afternoon. The patient had no history of heart disease or of symptoms referable to the cardiac or respiratory system, other than a brief episode of dull substernal pain three years earlier when running with two suitcases. His father and two brothers had died suddenly of coronary occlusion.

Examination at the time of admission to Wesley revealed a pale, ill, middle-aged white man with a pulse rate of 124, blood pressure of 100/50, and respiratory rate of 24. There were rales audible two-thirds of the way up both lung fields posteriorly. The first heart sound was diminished, and there was a grade 4/6 harsh systolic murmur which was loudest at the apex, but was easily heard throughout the precardium.

The liver was not felt. Peripheral arterial pulses were palpable.

Hematocrit was 48 and white blood cell count was normal. Urinalysis was normal except for the microscopic examination which revealed 5 to 8 red cells per high power field and 1 to 2 hyalin casts per low power field.

The patient was admitted to the coronary care unit at 3 P.M., January 22nd, and remained at bed rest. His hypotension and tachycardia persisted, and cardiac catheterization was performed that evening. Significant findings included elevated right ventricular pressures, 57/13 (normally under 30/6) and increased right ventricular oxygen saturation to 86.8% (normally less than 80%). The pulmonary blood flow was double the systemic, and inhaled hydrogen appeared in the pulmonary artery in only two seconds (normally 6 sec.). Cineangiography also demonstrated an apical ventricular septal defect. The patient failed to improve during the night as evidenced by persistent tachycardia and elevated central venous pressure, and by decreasing urinary output and blood pressure.

The next morning an operation was performed through a median sternotomy. The infarct, which involved most of the apex of the heart, was excised up to and including the defect in the interventricular septum. The open end of the heart was then closed by suturing the remaining septum to the right ventricular wall, and then suturing this to the remaining left ventricular wall.

Dr. Joseph Sherriek: The specimen consisted of several portions of left ventricle, the largest measuring 7 x 7 x 1 cm. In the sections, the pericardium shows a few scattered acute inflammatory cells, along the blood vessels of the myocardium. There are collections of neutrophilic leukocytes. In some areas the muscle is necrotic and fragmented, with focal recent hemorrhage and a slight acute inflammatory reaction. See Figure 1. In spite of this, the muscle is fairly intact, with well-preserved cross-striations. The presence of necrosis and acute inflammation is indicative of an acute recent myocardial infarct. The microscopic appearance is consistent with 3 days duration, as suggested by the clinical history.

Dr. Geier: In the early post-operative period the blood urea nitrogen level rose to a high of 112 mg% on the fourth postoperative day and then gradually decreased. His urine output was maintained satisfactorily throughout this period. On the fifteenth postoperative day he developed a fever which persisted for a few days. Loridine

was administered until it was noted that the BUN level had increased again. With fluid and electrolyte management and discontinuation of the Loridine, his BUN and creatinine returned to normal and he became asymptomatic.

Myocardial infarction has been of little interest to surgeons until recently. Now surgery has been used both to treat the complications of myocardial infarct and to prevent recurrence. Postinfarction rupture of the ventricular septum is one of the least common of the complications of myocardial infarction, accounting for only 1-2% of all fatalities due to infarcts. However, it is one of the most serious complications, because about a quarter of the patients die within 24 hours, two-thirds by two weeks, and 97% are dead within a year. Postinfarction rupture of the ventricular septum has been recognized since 1845, but was first repaired surgically in 1957 by Dr. Cooley. Since then there have been 65 cases reported in the literature.

Typically the rupture occurs about a week following a symptomatic infarct, but the range is from less than a day to over three weeks, and there has been at least one case reported in a silent infarct. The maximum tissue degeneration occurs at about this time following the infarct, and the infarcted area bulges paradoxically with systole, forming a shearing motion at the junction with the normal uninfarcted myocardium. It is interesting that this complication is more common in hypertensive patients, perhaps because they develop a greater shearing force. About two-thirds of the ruptures occur at the apex of the septum and the incidence progressively decreases higher on the septum. About 60% of the defects are between one and two centimeters in diameter with about half the remainder being smaller and half larger. Several cases have been reported with multiple small defects rather than one large one. As the infarct usually involves a large portion of the apex of the left ventricle, ventricular aneurysms are a commonly associated feature, (sometimes 40%).

Clinically, the typical patient has a known myocardial infarct and suddenly develops shock and/or congestive failure. In addition, a new systolic murmur appears which is quite loud. Nearly all the patients have a murmur, although a few of them have died before anyone had a chance to hear it. The murmur is indistinguishable from the murmur of the mitral insufficiency due to papillary muscle rupture or dysfunction, so cardiac catheterization is required for diagnosis. In the reported cases at least, there have not been fatalities or complications of any sig-

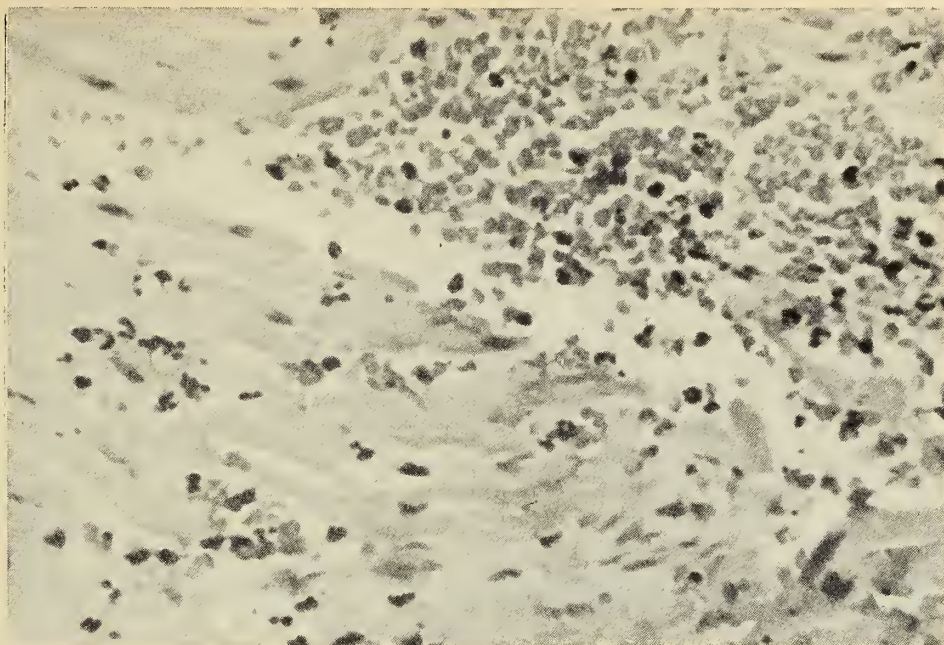


Figure 1. Microscopic sections demonstrated necrotic muscle with focal hemorrhage.

nificance due to the cardiac catheterization, despite the critical condition of these patients. Catheterization reveals one or a combination of four things: first, increased right ventricular pressure, as in our patient; second, an increase in pulmonary systemic flow ratio showing the shunt; early appearance of the hydrogen in the pulmonary artery; and lastly, cineangiography may or not demonstrate a shunt in the apex. Faced with a seven percent one year survival, surgical repair seems a reasonable alternative.

In the past a wait of 2-3 months after infarction has been considered desirable to allow fibrosis to progress to the point where the myocardium will hold sutures. However, since 80% of the patients are dead within 2 months, earlier intervention is indicated if the patient is deteriorating. Most of the defects have been closed primarily, with a felt patch. Most of these have been repaired through the right ventricle. Some surgeons have excised the infarcted area of the left ventricle, and then repaired the septum through this opening. The collected two month mortality has been 38% compared to 81% in the largest series of unoperated patients. The operative mortality and complications do not seem to be related to the timing of the operation following the infarct.

Dr. Arthur DeBoer: I think the case presented demonstrates primarily a method of treating cardiogenic shock. In order to make the discus-

sion more complete, I should like to elaborate on treatment of cardiogenic shock and the modes of therapy available today. Cardiogenic shock is defined as symptom complex with findings of a) systolic pressure below 90, b) urinary output of less than 20 cc. per hour, and c) a gradually diminished blood pressure with a gradual rise in centovenous pressure; the evidence of congestive failure. Cardiogenic shock occurs in approximately 10-30% of all the patients with myocardial infarction. The mortality of cardiogenic shock is estimated between 85 and 90%. So, with this kind of an outlook, what type of therapy do we have available? There are primarily four. One well-established mode of therapy would be the medical approach. The one drug of choice is epinephrine. By increasing resistance thereby increasing pressure, the cardiac work is increased and prolongation of the patient's life is not very effective. The second drug is Isoproterenol, which reacts in a little different fashion in that it has an inotropic effect on the heart, diminishing the central aortic pressure and thereby diminishes the coronary flow of the heart with already impaired circulation and thus the longevity of the patient is likewise ineffectively prolonged. There is an interesting drug that is now available which is the -levo preparation of (dihydroxyphenyl)-L-alanine which is popularly known as L-dopa. L-dopa is, as you know, broken down to dopa-

mine which in turn is converted into a combination of epinephrine and norepinephrine which looks as though it might be an interesting drug and may have some merit. The final drug sometimes used is a steroid. This drug is equivocal and debatable as to its effectiveness.

If we choose not to resort to drug therapy, the second mode of therapy would be some kind of a left ventricular assist. The most popular one right now, I believe, is some kind of an intraortic balloon. There are only a very few survivors with the use of the intraortic balloon on patients in cardiogenic shock, however, it does have some merit. It is a balloon that is placed distal to the aortic valve via the brachial artery and is timed very accurately to milliseconds on the electrocardiogram to inflate and deflate thereby increasing the circulation to the myocardium without increasing cardiac work. I have no experience with this particular approach, but it was discussed at Chicago Surgical Society not long ago. This requires not only a cardiac catheterization, but also a coronary angiogram. With a patient in shock, one wonders how detrimental this would be, because one must know the status of the coronary pattern before we can try to bypass the various obstructed vessels. The fourth mode of therapy is the one presented, namely, an infarctectomy. Because a ventricular septal defect, secondary to the myocardial infarction was diagnosed, one can choose a surgical approach quite readily. By correcting the left to right shunt besides excising the infarct, hopefully, dynamics can be expected to greatly increase the chances of survival. If the patient is progressively going downhill, then there is little doubt that something should be done surgically.

Since we're dealing with acute myocardial infarction with a ventricular septal defect, the mortality rate, without any therapy, as Dr. Geier mentioned, being around 85-90%, one has very little choice. This is the way we felt with this man. The differential diagnosis, however, of a dysfunctioning papillary muscle or ventricular septal defect cannot be made without catheterization. Both have the same type of murmur, a systolic murmur heard best in the apex. It is very important for us to know before we operate on these patients, whether we are dealing with mitral insufficiency due to papillary muscle dysfunction and need to replace the mitral valve, or a ventricular septal defect requiring some means to close the ventricular septal defect. Each has its specific approach. Most surgeons have come to the conclusion that the best way to

close this type of ventricular septal defect is through the left ventricle. It is difficult through the right ventricle because the heavy trabeculation masks the defect because of the various cornices of the papillary structures of the right ventricle, the medial portion of the right ventricle and the septum. Each ventricular cavity was closed separately. I don't believe there is any recorded case in the literature that has been operated upon this soon after the onset of the myocardial infarct. The earlier the VSD occurs following the myocardial infarction, the greater amount of muscle necrosis and therefore the larger the infarction and the higher the mortality. This man ruptured his septum the second day after his myocardial infarct, which is quite unusual, and the outlook is exceedingly poor. We have had experience with only three patients in whom a ventricular septal defect secondary to a myocardial infarct was treated surgically. In one patient we found improvement with aggressive medical therapy. Cardiac output increased, urinary output increased, but after three days of medical therapy, the patient suddenly became worse and within an hour became moribund.

I thought we should operate on the present patient although our experience of infarctectomy was minimal. I was anxious to see what benefit we could offer such a patient. I felt that even though the outlook of the patient was extremely grim, we should approach this surgically. I was pleased to find out that by removing the infarct one can suture partially necrotic muscle providing you have a large enough bolster and you can maintain a large enough cavity. Also afterward the heart function is much improved. In this man, because the infarct was so large, we had to excise all the necrotic muscle in order to remove the necrotic septum. Approximately 50% of the septum was removed which represented the lower half, as well as removing the apex of the ventricle. Once you get beyond the infarct, then there is fairly good substantial muscle to sew. This case represents one way of treating a patient who has had a myocardial infarction and is in cardiogenic shock.

Dr. John Beal: How do you treat the patient who is in cardiogenic shock from a ruptured papillary muscle?

Dr. DeBoer: The primary treatment there is to repair the valve or replace it with a prosthesis. The mortality isn't nearly as high, and I think that surgery can be postponed with mitral insufficiency secondary to a myocardial infarct because it isn't as lethal as a VSD. ◀

BY ROBERT R. HARTMAN, M.D./JACKSONVILLE

Maternal death study

Case report No. 3

The third in a series of case reports

ONE OF THE FUNCTIONS of the ISMS Committee on Maternal Welfare is to analyze the causes of deaths in Illinois mothers and to determine, if possible, what alterations in management and treatment could have prevented any of these deaths. Each month a case will be presented and discussed in an attempt to promote more modern methods of obstetrical management. It is with extreme gratitude that the assistance of the Illinois Department of Public Health is acknowledged. Without their initial collection and preparation of the cases and protocols these studies would be very limited.

Case Report:

This 42-year-old Gravida XIV Para XIII was admitted to the hospital with contractions of poor quality varying in intensity, frequency and duration. Her past history was that her first 11 children were born following what were described as essentially uncomplicated pregnancies, labors and deliveries. The twelfth pregnancy was complicated by placenta praevia which difficulty was solved by performing a classical Cesarean section. Tubal ligation had been advised at the time of this surgery, but the husband refused to give his permission for this procedure.

It was strongly suggested that she not become pregnant again, but pregnancy number 13 was managed by vaginal delivery without incident. Again sterilization was advised and contraceptive measures strongly counselled with an admonition that should she again conceive, she should be seen early and often during her pregnancy.

At approximately 32 weeks gestation and 30 pounds above her normal weight, the patient again reported to her physician's office. A weekly appointment schedule was set up, but the patient did not return for over 50 days. The importance of good care was again stressed, and the patient's next contact with the doctor was when she entered the hospital in early labor. After

approximately five hours of "light and variable contractions," she experienced sudden pain in the lower abdomen followed by rapid severe shock, with death occurring 10 minutes later. The autopsy showed a 10-inch right lateral uterine rent with resultant massive intrabdominal hemorrhage.

It seemed to your committee that this death from obstetrical hemorrhage was due primarily to poor patient cooperation. However, the wisdom of allowing a gravida XIV labor for five hours with a uterus scarred by multiple pregnancies as well as a previous Cesarean section seemed open to question.

Perhaps one of the most difficult problems of the conscientious physician is that of continuing to provide the best possible care, free of prejudice, for the ignorant and uncooperative patient who presents herself without warning at the hospital at one o'clock in the morning. In retrospect, repeat section would probably have saved this patient's life. However, your committee felt that this amount of bleeding occurring with such rapidity is quite unusual and even under ideal circumstances it would have been impossible, once it began, to have reversed the fatal outcome. ◀

CHICAGO SYMPHONY ORCHESTRA—TOURING EUROPE

How does one go about being the doctor 115 musicians ranging in age from the early 20's to the late 60's? First hand experience as Official Tour Physician to a traveling symphony provides some answers. Because illness has no respect for age, prompt medical care is a necessity for the musicians while on the road. Mild or catastrophic ailments are apt to occur in the middle age group.

From August 26 to October 6, this writer was privileged to be the physician for the Chicago Symphony Orchestra's first European Six Week Concert Tour. Nine countries and fifteen major cities were visited.

All the capital cities visited in Western Europe had good sanitation and hygienic conditions.

As you might expect, the responsibilities of the attending doctor were many and varied, especially in strange cities where language was a barrier. In order to deal adequately with any contingency, a table of priorities was organized. Pre-existing illnesses had to be dealt with, hospital services anticipated and medicinal preparations provided to cover general and varied conditions. Only minimal equipment in addition to medications could be taken.

The first consideration for the Tour Physician to bear in mind was the kind and type of traveling group to be served. The Chicago Symphony Orchestra numbered 115 professional musicians, 110 men and 5 women. They are educated, intelligent, sensitive artists. Many, in addition to being performing artists, are expert teachers dedicated to their art of making good music, and also people pursuing unusual, interesting and varied hobbies. As a fellow traveler, the attending doctor had to be able to understand the group as individuals and exhibit an interest in their main objective, in this instance, playing a symphony concert to the best of their ability.

The Symphony traveled by chartered plane. A separate cargo plane carried wardrobe trunks

and carefully packed musical instrument trunks, approximately 200 pieces of precious baggage in all. Exact timing in dispatching this valuable cargo to the exact city and concert hall was absolutely essential. Without instruments there could be no concert.

Promptly upon arrival at the specific city, large trailer trucks were waiting at the airport. Stagehands, who traveled with us, methodically and carefully supervised the transfer of the cargo onto the trucks and away to the concert hall. Then, the unloading began in systematic sequence with instrument trunks set out in the same floor plan as the instruments on stage.

These are the people who make it possible for a concert tour of this dimension to be carried out smoothly, orderly and promptly. They are my unsung heroes, unknown and unseen. Their work starts early in the day and carries on late into the night long after the performance is over. The packing, loading, and unloading from one destination to another were their important responsibilities. The orchestra and conductor on stage recreate the music and are glamorized and applauded generously. Backstage two to three men unapplauded go about the laborious task of putting the show on the road.

During the week after arrival on the continent, the group had its first casualty when a musician slipped and fell, rupturing the Quadriceps muscle of his right thigh. On the following morning, surgery was done in one of the hospitals on our list. This accident impressed upon me the fine esprit de corps of these men

and the high regard they hold for each other. Their deep concern, words of sympathy for speedy recovery, were freely and touchingly expressed. The conductors joined in showing their personal feelings also. The close friendship and unity may be one reason for the high quality of the musicians' playing. They are a big happy family in spite of diverse backgrounds and ethnic groups.

If musicians are supposed to be temperamental, I failed to find it. They are serious artists. Prior to rehearsal and performance they can be heard practicing singly or in groups. Even during their twenty minute break they continue to practice. They enjoy a diversity of interests beyond music making. Many are avid photographers, some golf, others go fishing. Reading and playing chess come high on the list. Most have traveled extensively, are multi-lingual, and a few are good pinochle players. Others are interested in world affairs, politics, economics, and if left to them, the ills of the world could be healed, the Viet Nam war ended and our economy turned upward.

Taking into consideration the multi-faceted personalities of the traveling musicians, the following program and format was followed:

1. Arrangements for hospital care in case of emergency. The International Hospital Federation was asked for a list of hospitals in the fifteen European cities where the orchestra performed. Their response was prompt and each answered most cooperatively. For example, in Goteberg, Sweden the hospital administrator offered the professional facilities in the 2000 bed hospital. He added that the staff would be honored if the Chicago Symphony Orchestra were to give a performance in their new, large auditorium.

2. Medical Histories were obtained from each of the members. A questionnaire was sent to each member advising him to consult his own doctor, especially if he were under medical care for any ailment. Allergies, Diabetes, Heart Disease, Hypertension and any past ailment were to be indicated. His doctor's advice and recommendations were requested. 70% responded.

3. Medications were stocked for the trip. A wardrobe trunk was converted into a Mobile Medical Dispensary. 35-40 different medications in plastic containers, lined the shelves and drawers. No liquid medications were carried because of difficulties in dispensing.

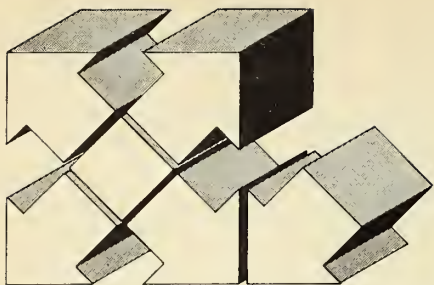
Every possible illness was considered, whether it would be Gastro-Intestinal, Cardio-Respira-

tory, Urological, or of the Central Nervous System. For each, proper medication was provided; Anti-Histamines and Steroids for allergies; Antibiotics for infections; Tranquilizers and Sedatives. Analgesics (except narcotics) for mild pain, and vitamins made up the balance of the medical dispensary. Clearance was given by the local offices of the foreign consulates representing the nine European countries to be visited. No narcotics were taken. If severe pain was encountered, hospital facilities were at hand for diagnostic examinations and for treatment. A First-Aid Kit plus disposable syringes were also included.

Equipment which would have been heavy and difficult to move was not taken. For example, an EKG unit, even though portable, was excluded. It was reasoned that if such an examination were needed, local listed hospitals would have provided such a service either on an emergency or an elective basis. It was essential to travel light and efficiently. The medicinal unit was always quickly at hand. Office hours were arranged each afternoon in a hotel room, with the room number listed in the hotel lobby for the convenience of all involved. Examinations were made and from the medicinal unit, medications were dispensed. This arrangement served our purpose, under the prevailing conditions, and was a reminder of medical practice in the early part of this century.

During office hours, members of the orchestra, their families, administrative staff, non-playing tour members, the maestros, management, members of the orchestra association, etc. received treatment. Prior to each rehearsal and performance, time was provided to consult with any musician about his health not covered during office hours. Medication was provided promptly when indicated. Aside from general illnesses which can ever be present, two occupational hazards are worrisome to these musicians. String instrumentalists fear Bursitis and Arthritis of their bowing arm. Wind players fear dental problems, Labial Herpes, and above all, pulmonary diseases. Reluctantly I injected one of the violinists with a Steroid for a long standing Bursitis of his right elbow (tennis elbow). His relief was so complete that on the next day, four more string players were waiting in my office for injections. They were treated, responded favorably and were free from pain. Labial Herpetic lesions of the wind players responded well to Steroids.

Throughout the entire tour only five man
(Continued on page 502)



trauma center

BY ROBERT J. LOWE, M.D., TERESA L. ROMANO, B.S.N., AND DAVID R. BOYD M.D.C.M./CHICAGO

Initial Care—

Of Critically Injured

The initial identification and early care of a critical injury are crucial determinants to a successful outcome after major trauma. The responsibility for proper early care belongs to all health professionals and law enforcement officers who commonly attend the acutely injured. The Illinois Statewide Trauma Program is attempting to upgrade patient care by providing a system that will insure the ready availability of optimal medical care for the injured.¹ This total systems approach extends from the scene of the accident through the rehabilitation phase after a major injury. All levels of health care personnel are being integrated into this system. Ambulance attendants, allied health personnel, nurses and physicians in Illinois are participating in this new system designed to provide the best possible medical care to victims of major trauma.

The initial phase of the Illinois Trauma Program addressed itself to the establishment of forty Trauma Care Centers across the State.² These designated centers are staffed and equipped to provide for the complex needs of the critically injured patient and are being established in strategic locations where medical resources are available. In the Illinois Statewide Program, emphasis is given to the education and training of all health professionals, especially health care providers of the primary delivery

system. An eighty-two hour course for "Emergency Medical Technician-Ambulance" (EMT-A) is underway in ten Trauma Centers and will soon be established in all.³ The EMT will staff ambulances and will be responsible for patient care during the transportation of the critically injured.

At the Regional Trauma Centers an intensive, four week course for the development of a trauma nurse specialist is underway.⁴ This post-graduate nurse training course stresses the early

recognition of important pathophysiologic signs and other derangements associated with major trauma. Appropriate emphasis of this course is placed on the modern methods of care during the initial phases after injury.

This educational effort to improve medical expertise in the management of the critically injured also involves training programs for physicians and medical students. The medical staffs of the Trauma Centers have taken an active role in upgrading the emergency medical services they provide. Review courses, seminars, and surgical grand rounds, all dealing with aspects of the critically injured patient, are being offered by physicians. These efforts have been responsible for a renewed interest in the trauma patient. In addition, a new health professional, the Emergency Physician, is emerging. The American College of Emergency Physician (ACEP) currently offers many courses on the care of the acutely ill and injured. An approved residency program in "Emergency Medicine" is now being contemplated for the Evanston Regional Trauma Center.

The Critical Injury Index

To enable all members of the health care team to better define those accident victims with critical injuries, a descriptive scale has been developed. This is a list of the ten most important features of serious injuries, which are described in non-medical terms. This index facilitates communication between all members of the health care team by providing a common, simplified basis upon which to evaluate a patient.

Law enforcement officers are usually the first persons at the accident scene and can, by quickly identifying any of the abnormalities listed on the Critical Injury Index (Figure I), determine the necessity of transportation of the patient to a Trauma Center. Any ambulance attendant can describe these findings over a two-way radio system to a physician at the trauma receiving center. These statements are descriptions of the attendants' findings and are not to be misconstrued as diagnoses. Nurses will be better able to communicate in this system with the aid of the Injury Index. Most critical observations can be made by direct visual means and by simple palpation. Blood pressure is not included in the index because many times those persons first at the scene do not have the capability of measuring this parameter.

The Critical Injury Index has been printed on pocket size cards (4 in. x 4 in.) for easy access in times of emergency. Also, large sun visor sized

cards (5 in. x 9 in.) have been printed. On the back of these cards is a list of the Regional Emergency Dialing Numbers (RED NUMBERS). These telephone numbers will alert the nearest Trauma Center that a serious accident has occurred in its vicinity. The Trauma Center can then prepare for reception of the types of injuries described. Over 15,000 index cards have been distributed across the State.

Priorities of Management

Obviously, preservation of life is the first objective in the care of the critically injured. In this situation, it is impossible to separate diagnostic and therapeutic measures. Certain conditions demand immediate attention: a patent airway, adequate ventilation and cardiac function must be supported. Major external hemorrhage must be stopped. Shock treatment must be promptly initiated. Fractures should be properly splinted and open wounds covered with sterile dressings. After this a thorough physical examination must be performed.⁵ These functions can and must be performed at the scene of the accident, during transportation, and maintained during the entire acute post traumatic period. These measures must be instituted by all trained personnel involved with the care of the injured including emergency medical technicians, trauma nurses, and emergency physicians and surgeons.

Patients with complex, multiple-system injuries often require the skills of many specialists. In these cases it is essential that one physician assume the role of the patient's primary physician. This person remains in charge during the entire course of the illness. He coordinates the efforts of other consultants utilizing established priorities. This team concept is carried through the operative and acute post-traumatic period. When the patient can be safely managed by one specialist, he is then released to his care.

Patients may need to be moved to a more distant facility or to other remote areas in the hospital, such as the X-ray department for additional evaluation and treatment. During this period they should be continuously observed by a physician, nurse, or highly qualified EMT-A. Once a patient has been stabilized he can be moved to the intensive care unit for additional monitoring or to the operating room as indicated. Also, transportation to distant centers can be safely performed when the patient is fully resuscitated.

I. Maintenance of the Airway

The first priority in any trauma patient is the establishment and maintenance of a patent

"So that others may live"

STATE OF ILLINOIS

RICHARD B. OGILVIE, GOVERNOR

CRITICAL INJURY INDEX

SYSTEM:	ABNORMAL	SEVERELY ABNORMAL
1. Airway	abstructed, partially by foreign object	obstructed, completely by injury
2. Breathing	shallow or uneven	labored or undetectible
3. Respirations	24 - 36 per minute	below 16, above 40 per minute
4. Bleeding	minor, controlled by external pressure	massive, uncontrollable by simple pressure
5. Pulse	90 - 120 per minute	irregular or none, below 60 or above 120 per minute
6. Wounds	superficial, multiple lacerations, or abrasions	major, deep, or with loss of body parts
7. Fractures	deformed extremity, stable, closed	bone exposed, unstable open
8. Extremity sensation	any change in feeling, tingling, burning	loss of feeling (anesthetic)
9. Extremity movement	any limitation of voluntary motion, or weakness	loss of functions (paralyzed)
10. Mental state	excited, intoxicated	depressed, unconscious (coma)

Identify the most severe category and report in the order as listed (that is airway - abstructed with vomit, breathing - uneven, mental state - confused, etc.) Identify bleeding location, seriousness, and contrallable; fracture sites, and amputation or near amputations.

DIVISION OF EMERGENCY MEDICAL SERVICES ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Figure 1. The Critical Injury Index which is being utilized by ambulance personnel and law enforcement officers for a better initial description of major injuries.

upper airway. Patients with depressed consciousness from intoxication, cerebral injury, or shock are high-risk candidates for aspiration of foreign material such as blood, food, vomitus, and dentures. A pharyngeal block with adequate aspiration and removal of these foreign materials is mandatory. The patient must be closely observed and suctioned frequently. He must not be allowed to lie flat on his back, unattended or restrained in this position. The coma (semiprone)

position is satisfactory. Some commonly occurring causes of upper airway obstruction include bleeding and edema of the mouth, tongue, posterior pharyngeal wall, and epiglottis. Penetrating wounds of these parts are particularly dangerous. Cervical spine injuries with vertebral subluxation and hematoma formation can compromise the upper airway. Severe facial trauma with obliteration of the nasal passage will contribute to these problems. Respiratory distress

with stridor, a contusion of the neck, and history of steering wheel injury must alert one to the possibility of a fracture of the larynx or trachea. Endotracheal intubation will be unsuccessful in this case and an emergency tracheostomy may be necessary. When manipulating the head and neck for such procedures, an educated appraisal of the cervical spine is mandatory. A patient with abdominal breathing only may have a cervical vertebral dislocation with spinal cord injury. Rough manipulation may complete a partial transection of the spinal cord. Vascular injuries of the neck with hematoma formation may be troublesome and require airway control. Combative patients with hypoxia from airway obstruction or major chest injuries can be safely intubated with the use of a rapidly acting neuromuscular depolarizing agent. Primary tracheostomy is almost never indicated today except for patients with major upper airway obstruction from severe facial trauma, massive soft tissue trauma and cervical vertebral dislocation. Although tracheostomy is easy in a non-emergent situation, it is extremely risky in patients who are restless and agitated from hypoxia. Primary endotracheal intubation followed by controlled tracheostomy is the safest approach.

II. Ventilation

There are three essential components involved in normal respiration: (1) a patent airway system for transporting oxygen down to the alveolar-capillary unit, (2) alveolar-capillary units (the functional unit of the lung) in sufficient number, and (3) an intact central nervous regulatory system that responds to changes in the internal environment of the patient. Assessment of the ventilatory adequacy of the patient should be done by physical examination and supported by the determination of arterial blood gases. The management of the upper airway has been discussed. The provision of an adequate number of functioning alveoli is involved in the proper management of major chest injuries: (e.g. pneumothorax, tension pneumothorax, hemothorax, open sucking chest wounds and flail or unstable chest wall segments). The proper initial management of any of these injuries demands the use of needle aspiration, occlusive dressings, chest tubes and water seal drainage. The central nervous system regulatory system is vulnerable to direct cerebral trauma and hypoxia. Cervical spinal cord lesions may cause paralysis of the chest wall musculature. This derangement will require the use of mechanical ventilatory assistance.

III. Cardiac Function

The competency of the circulatory system must be quickly assessed. Absence of an audible heart beat or a palpable femoral, radial or carotid pulse indicates a cardiac arrest. Major causes of a cardiac arrest are hypoxia and profound metabolic acidosis. Direct trauma to the heart may cause cardiac tamponade and cardiac arrest. Rarely, a fatal arrhythmia may be triggered by indirect trauma. Standard cardiac arrest procedures, including defibrillation, must be administered immediately. Closed cardiac compression is preferred. However, in a patient with a penetrating chest injury or severe flail chest, cardiac arrest may require emergent thoracotomy and open cardiac massage.

IV. Control of Hemorrhage

Major external hemorrhage can usually be controlled by direct pressure over or proximal to the bleeding site. Use of tourniquets is unacceptable and inappropriate. Blind clamping of vessels is also to be condemned as it jeopardizes the chances of performing a successful vascular repair. Continued pressure is all that is necessary to maintain control of hemorrhage until arrival at the operating room for definitive treatment. Internal hemorrhage often requires surgical intervention for its proper management after vigorous blood replacement.

V. Shock

The essential steps in the resuscitation of a patient with hypovolemic shock include the insertion of at least two large bore (#14) polyethylene intravenous catheters. One should be centrally placed to enable the measurement of the central venous pressure (CVP).⁶ A urethral catheter is inserted to monitor hourly urine output and to evaluate the effect of blood volume replacement. Determination of arterial blood gases should be obtained early and repeatedly during the acute resuscitation period.

In all cases, the restoration of the loss in circulating blood volume initially with a balanced salt solution and followed by type specific, cross-matched whole blood is the key to the successful management of hemorrhagic shock. Adequacy of the oxygen carrying capacity can be maintained by a hematocrit value above thirty per cent. Plasma, albumin, or dextran solutions may be effectively used when the need for volume replacement is acute and whole blood is not available. Bicarbonate must be given to combat the metabolic acidosis that develops in advanced degrees of shock.

Blood pressure, pulse, respiratory rate, C.V.P., urine output, skin temperature, level of consciousness, and arterial blood gases should all be repeatedly observed and recorded during the resuscitation period. Presence of an adequate urine output (30 ml/hr in an adult) usually indicates adequate tissue perfusion as does the return of a normal level of consciousness and skin temperature. The C.V.P. is important as relative changes are determined in sequential measurements and provide one of the most important parameters in which to judge the restoration of the circulating blood volume.

VI. Fractures and Soft Tissue Injuries

Gross fractures of an extremity are easily identified by simple inspection and palpation. Grossly deformed limbs should be gently returned to an anatomical position and then adequately splinted. Pneumatic and Thomas splints should be available in every ambulance and emergency room. Proper care will prevent a closed fracture from becoming an open one. One should also take note of the presence of distal pulses before and after manipulation of a deformed extremity.

The old principle of first do no harm applies to soft tissue wounds. Covering the wound with a sterile, occlusive dressing without extensive manipulation or probing is the best possible service. Only when the wound can be properly cared for in a sterile environment should the dressing be removed. At that time, the wound should be meticulously cleansed and debrided. Soft tissue injuries should be repaired within the proper time sequence of overall care of the patient.⁷

VII. Neurological Evaluation

The level of consciousness must be serially evaluated and subtle changes assessed by trained personnel. The pupillary reflexes, cranial nerve

function and gross neurologic function must be evaluated. Extremity motion and sensation must be initially and repeatedly assessed. These findings must be consistently recorded. It is the early recognition of these neurologic changes that will effect a major improvement in the final outcome of many critically injured patients.

VIII. Overall Clinical Evaluation

At this point, a complete physical examination is performed and a pertinent history obtained. One should determine the mechanism and time of injury and any prior treatment given at the referring hospital. All patients should be completely disrobed for this physical examination which will reveal many important physical injuries and unsuspected clinical problems.

IX. Laboratory Studies

The minimal acceptable diagnostic work-up includes a hematocrit and urinalysis. Serum and urine amylase determinations are helpful when evaluating pancreatic or duodenal injuries. An electrocardiogram (ECG) and serum enzymes should be obtained in all patients with major chest trauma and those that may have sustained myocardial injury. Arterial blood gases should be obtained in all patients with major trauma. Elevations in the serum osmolality have been observed in patients with traumatic shock. These elevations correlate well with lactic acid levels.⁸ Complex fluid problems including transient diabetes insipidus can be better managed with the use of serum and urine osmolality determinations. Shock and trauma are also associated with major alterations in the hemostatic mechanisms and a coagulation profile should be obtained in all patients with massive trauma.⁹

X. Roentgenograms

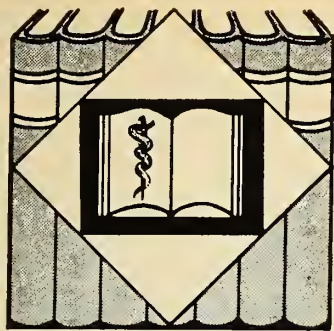
An aggressive diagnostic approach is necessary
(Continued on page 502)

ROBERT J. LOWE, M.D. (left) is currently a surgical resident at Cook County Hospital and has been instrumental in the creation of the Trauma Registry, a computerized medical records system used throughout the Illinois Statewide Trauma System. He received his M.D. from Loyola University.

TERESA L. ROMANO, B.S.N. (center) received her degree from the University of Illinois. She is the Chief Trauma Nurse Coordinator for the Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health and has devised and implemented the four week course for the training of trauma nurse specialists.

DAVID R. BOYD, M.D.C.M. (right) is the Chief of the Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health and Assistant Professor of Surgery at the University of Illinois, Abraham Lincoln School of Medicine. He received his M.D.C.M. from McGill University in Montreal, Canada.





the doctors library

Immunological Diseases. Volumes 1 and 2. 2nd Edition. Edited by Max Samter. 1,383 pages. Little, Brown and Co., Boston, 1971. \$45.00.

This is the second edition of a scholarly and detailed two-volume offering concerning one of the most rapidly-growing fields in medicine. One hundred and five authors, including 71 new authors, have contributed their knowledge in the field of immunology. It is divided mainly into five parts. The first 400 pages cover "Basic Immunology." The next portion consists of "Non-atopic Immunological Disorders," "The Atopic Diseases," "Allergic Reaction Patterns of the Skin," and "Diseases with Immunological Features."

Under these headings we find a variety of diseases, allergic reactions, and syndromes that extend from drug reactions to allograft rejection.

Diseases, such as syphilis, poststreptococcal diseases, and histoplasmosis, etc., are listed in the section entitled "Hypersensitivity to Infectious Agents." Well-established atopic diseases, and allergic patterns of the skin are given another 200 pages. Among the most interesting are the diseases with immunological features. These include systemic lupus erythematosus, rheumatoid arthritis, amyloidosis, and the like. And, the authors also include diseases of the exocrine and endocrine systems.

This is a fine book—but it may be a bit too difficult for one not familiar with modern molecular biology, in particular, and immune response, in general. The two-volume set is expensive (\$45.00), but worthwhile for those interested in this fascinating field.

T. R. Van Dellen, M.D.
Editor

The Coronary Care Unit. By William J. Grace and Victor Keyloun. Published in 1970 by Appleton-Century-Crofts. 223 p. Illus. \$8.50.

Intensive coronary care has become an essential part of the management wherever patients with acute coronary artery disease are treated. Although extensive information on coronary care has appeared, scattered through all sorts of recent medical publications, the practicing physician can profit from a summary in a readily accessible source for practical advice about how to do it. William J. Grace and Victor Keyloun have provided such a summary, published in May 1970, based upon their experience at St. Vincent's Hospital and Medical Center in New York City.

In their experience, prevention and control of cardiac arrhythmias has been most effective in the intensive coronary care unit and has been the main reason that they have been able to salvage about half the patients who might otherwise have succumbed. Control of shock and congestive heart failure has shown less improvement in such units. The authors devote little attention to the psychological problems within the units and following release from them.

The book deserves strong recommendation to all physicians who treat patients with coronary artery disease and may hold some helpful hints for those devoted nurses who have made these units work so well. For the nurses, however, simpler texts are already available that serve better for basic instruction. The greatest benefits of these special units will be realized only by those who know how to use them properly.

William H. Wehrmacher, M.D.



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.
Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed: SINGLE CHEMICALS

ANTIMINTH: Anthelmintics R

Manufacturer: Roerig

Nonproprietary Name: Pyrantel pamoate

Indications: Ascariasis and enterobiasis

Contraindications: Use with caution in patients with pre-existing liver dysfunction.

Dosage: 11 mg. per kg. of body weight (or 5 mg./lb.)
Maximum total dose 1 gm.

Supplied: Suspension, each cc. contains 50 mg.

DUPLICATE SINGLE PRODUCTS

DEMA Antibiotic—B&M Spectrum R

Manufacturer: USV

Nonproprietary Name: Tetracycline HCl

Indications: Infection due to susceptible organisms; adjunctive therapy in severe acne.

Warning: Use during tooth development may cause permanent discoloration of teeth. Excessive systemic accumulation and liver toxicity if renal impairment exists. Photosensitivity in some individuals.

Dosage: Adult: 1-2 gm. daily in 4 equal doses Children: 10 to 20 mg. per pound in 4 equal doses

Supplied: Capsules, 250 mg.

NITROSTAT Vasodilator—Coronary R

Manufacturer: Parke Davis

Nonproprietary Name: Nitroglycerin

Indications: Acute angina attacks

Dosage: 0.3 to 0.6 mg. sublingually as needed

Supplied: Sublingual tablets, 0.3 mg., 0.4 mg., 0.6 mg.

OPTIMIL Hypnotic—Nonbarbiturate R

Manufacturer: Wallace

Nonproprietary Name: Methaqualone HCl

Indications: Insomnia

Contraindications: Use with psychotropic drugs or other CNS depressants. Not for children under 14

and women who are or may become pregnant.

Warnings: Do not drive or operate machinery.

Dosage: 200 mg. or 400 mg. taken 15 to 30 mins. before retiring.

Supplied: Capsules, 200 mg. and 400 mg.

SDPH Anticonvulsant R

Manufacturer: Rachelle

Nonproprietary Name: Diphenylhydantoin sodium

Indications: Status epilepticus grand mal type and prevention and treatment of seizures occurring during neurosurgery.

Warning: Intravenous administration should not exceed 50 mg. per minute.

Dosage: Intravenously: Status epilepticus: 150 to 250 mg. administered slowly, then 100 to 150 mg. thirty minutes later. Neurosurgery: prophylactic dosage is 100 to 200 mg.

Supplied: Vials, 100 mg. and 250 mg.

COMBINATION PRODUCTS

PRENAL PLUS Prenatal Vitamin R

Manufacturer: Lemmon

Composition: Each tablet contains:

Vitamin A	6000	Units
Vitamin D	400	Units
Ascorbic Acid	60.0	mg.
Folic Acid	1.0	mg.
Niacinamide	15.0	mg.
Riboflavin	2.0	mg.
Thiamine Monohydrate	1.85	mg.
Pyridoxine HCl	3.0	mg.
Cyanocobalamin	8.0	mcg.
Iodine (as Calcium Iodate)	0.125	mg.
Iron (as Ferrous fumarate)	50.0	mg.
Calcium (as Calcium carbonate)	250.0	mg.

Indications: Prenatal Vitamin-Mineral Supplement

Dosage: 1 tablet daily

Supplied: Tablets

NEW DOSAGE FORMS

LINDEX OINTMENT 0.5% Corticoids—Local R

Manufacturer: Syntex

Nonproprietary Name: Fluocinonide

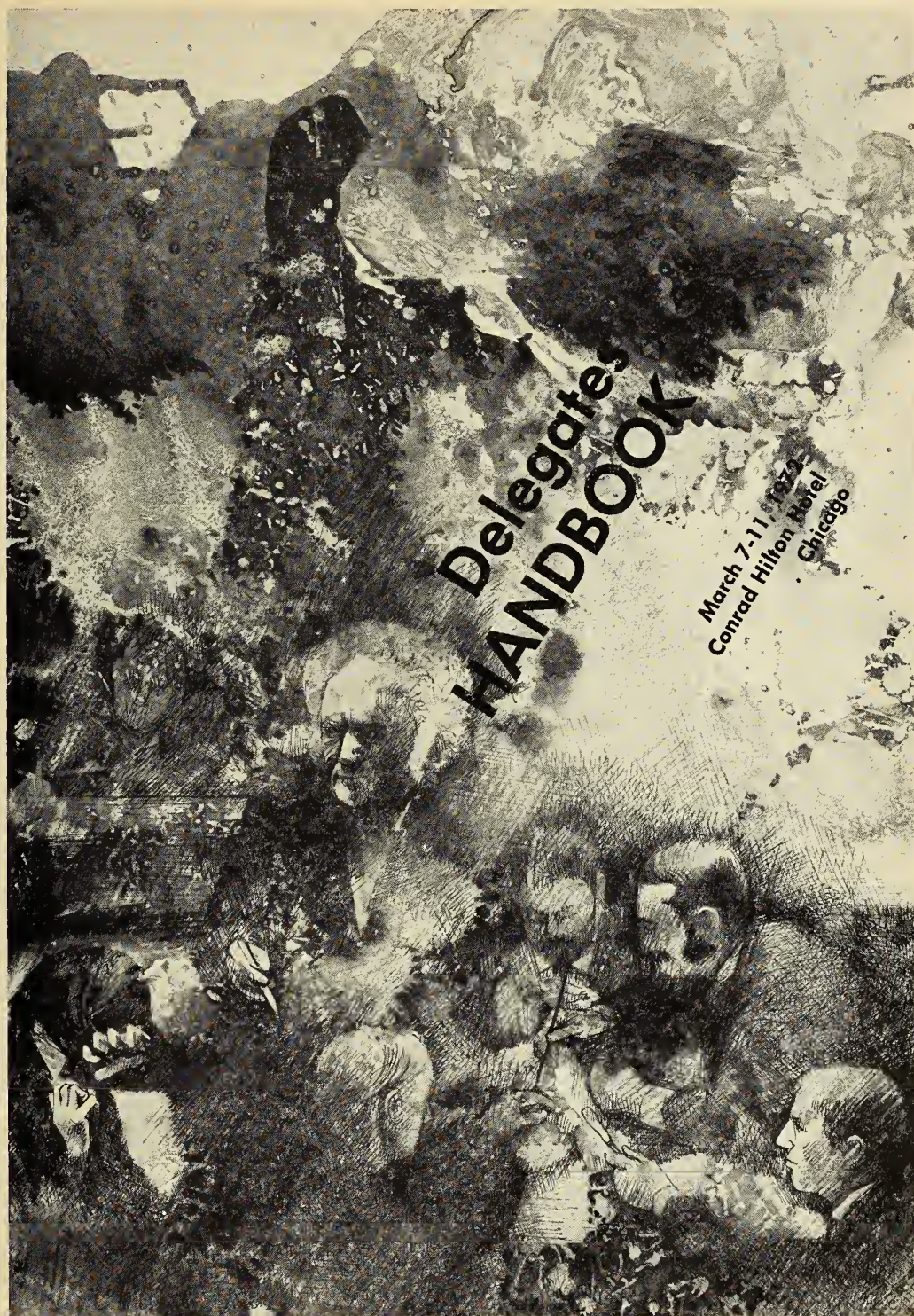
Indications: Adjunctive therapy in inflammatory manifestations of acute and chronic corticosteroid responsive dermatoses.

Contraindications: Vaccinia and varicella

Dosage: Apply 3 or 4 times daily as needed

Supplied: Tubes, 15 gm. and 60 gm.

132nd ANNUAL CONVENTION



**NEW OFFICERS & TRUSTEES
HIGHLIGHTS OF CONVENTION
SUMMARY OF HOUSE ACTIONS**

Illinois State Medical Society

1972-73 Officers

and

Board of Trustees

Officers

PRESIDENT	Frank J. Jirka, 1507 Keystone, River Forest 60305
PRESIDENT-ELECT	Willard C. Scrivner, Suit 2, 6600 W. Main, Belleville 62223
1st VICE-PRES.	Joseph Skom, 707 Fairbanks Ct., Chicago 60611
2nd VICE-PRES.	Glen Tomlinson, Fantus Clinic, Cook County Hosp., 1825 W. Harrison, Chicago 60612
SEC.-TREAS.	Jacob E. Reisch, 1129 S. 2nd St., Springfield 62704

House of Delegates

SPEAKER	Paul W. Sunderland, 214 N. Sangamon St., Gibson City 60936
VICE-SPEAKER	Andrew J. Brislen, 6060 W. Drexel Blvd., Chicago 60637

Trustees

1st Dist.	1974	Joseph L. Bordenave, 1665 South St., Geneva 60134
2nd Dist.	1974	Allan L. Goslin, 712 N. Bloomington, Streator 61364
3rd Dist.	1973	David S. Fox, 20829 Greenwood Center Ct., Olympia Fields 60461
	1973	Robert T. Fox, 2136 Robin Crest, Glenview 60025
	1975	Eugene T. Hoban, 6429 North Ave., Oak Park 60302
	1975	Fredric D. Lake, 1041 Michigan Avenue, Evanston 60202
	1974	William M. Lees, 6518 N. Nokomis, Lincolnwood 60646
	1974	George Shropshear, 1525 E. 53rd, Chicago 60615
	1974	Philip G. Thomsen, 13826 Lincoln, Dolton 60419
	1973	Frederick E. Weiss, 15643 Lincoln, Harvey 60426
	1975	Warren Young, 3450 Haweswood Dr., Crete 60417
4th Dist.	1973	Fred Z. White, 723 N. 2nd St., Chillicothe 61523
5th Dist.	1973	A. Edward Livingston, 326 Fairway Dr., Bloomington 61701
6th Dist.	1975	Mather Pfeifferberger, State and Wall, St., Alton 62002
7th Dist.	1973	Arthur F. Goodyear, 142 E. Prairie, Decatur 62523
8th Dist.	1973	Eugene P. Johnson, P.O. Box 68, Casey 62420
9th Dist.	1975	Warren D. Tuttle, 203 N. Vine St., Harrisburg 62946
10th Dist.	1975	Herbert Dexheimer, 301 S. Illinois, Belleville 62220
11th Dist.	1974	Joseph R. O'Donnell, 444 Park, Glen Ellyn 60137

Chairman of the Board Trustee-At-Large

William M. Lees, 6518 N. Nokomis, Lincolnwood 60646
Charles J. Jannings III, 101 E. Center, Fairfield 62837

Highlights of Convention



ISMS president pro-tem Charles J. Jannings, III, presents the president's medallion to Dr. Frank J. Jirka, Jr. during his installation as president.

The extension of Blue Cross insurance coverage to new "mini-hospitals" was recommended by the Illinois State Medical Society during its annual meeting. ISMS president, Dr. Frank J. Jirka, Jr., observed that, "Patients going to the 'mini-hospitals' or outpatient clinics, would undergo certain medical and surgical procedures and go home the same day, avoiding expensive hospitalization.

"Hospitalization accounts for about 40 cents of every health care dollar spent and is a major factor in spiralling cost of care," he noted.

"Yet under most insurance programs, including Blue Cross, coverage begins with hospitalization. So many medical and surgical procedures which could be done on an outpatient basis are done in the hospital.

ISMS has recommended that legislation be introduced to permit Blue Cross to extend its coverage. Since Blue Cross is a not-for-profit corporation, it falls outside the state insurance code.

In a long range plan to cope with the health manpower shortage, ISMS approved the concept of a physician assistant program in Illinois.

"The assistant, working under the supervision of a licensed physician, could help ease the doctor-shortage in ghetto or rural areas. Illinois presently has no training or certification programs for physician assistants, although State Senator Robert Coulson, R. Waukegan, has introduced legislation to establish the program."

The society recommended a one-year moratorium be observed in certification of physician assistants, but voted to support the Coulson bill if it limits employment of assistants to physicians in private practice.

"Too many of these assistants end up in hospitals and not out in doctor-short areas where they're most needed," Dr. Jirka emphasized.

Medical students, interns and residents will be accorded full membership benefits in the state medical society under another proposal approved during the convention.

The AMA last year voted to give students, interns and residents more voice in the medical profession by creating a special membership status. Since then 14 state medical societies have followed suit, including Illinois.

Citing nutritional deficiencies as a contributing factor in health problems in the ghetto and other depressed areas, the society recommended the government standard food budget for welfare recipients be increased from 27 cents per meal per person to 40 cents.



President pro-tem Charles J. Jannings, III (r), presents an AMA-ERF check in the amount of \$186,175 to Dr. William Grove (l), executive dean of the University of Illinois College of Medicine, to be distributed among Illinois medical schools.



Dr. Jacob E. Reisch, ISMS secretary-treasurer presents a memorial plaque to Mrs. L. T. (Virginia) Fruin, widow of ISMS president Dr. L. T. Fruin who died in office Feb. 5, 1972.

Attendance Totals

Attendance at the 132nd Annual Convention was as follows:

Physicians	2464
Medical Assistants	206
Woman's Auxiliary	384
Guests	951
Exhibitors	578
Total	4583

"Doctor's Doctor" Receives AMA Medicine and Religion Award

Dr. Paul S. Rhoades was presented the AMA Medicine-Religion Award for his work in bringing the clergy and medical profession closer together to function as a team in patient care. Dr. Walter C. Bornemeier, past president of the AMA, presented the award to Dr. Rhoades, commonly known as the "doctor's doctor."

Medical Assistants Ask Doctors To Vote "No" on P.A.s

Miss Jean Berchinski, president of the Illinois Society, American Association of Medical Assistants, urged the House of Delegates to carefully consider Resolution 72M-24 which called for ISMS support of legislation certifying physician assistants in Illinois. On behalf of her group

she discouraged the resolution, but pledged support and help should the physicians decide in the affirmative.

"Getting in There and Doing It" —Woman's Auxiliary Report

Mrs. David Kweder, president of the Woman's Auxiliary to ISMS, reviewed the activities of the past year. Bicycle safety programs, blood donor programs, mastectomy rehabilitation centers and "Threshold," a treatment zone for emotionally disturbed youngsters, were just a few of the auxiliaries' projects. On the national level, the Illinois auxiliary directed its attention to Project HOPE and the American Indians. Mrs. Kweder reported that the year was also successful with an increase in membership of 219. She indicated that efforts are underway to establish more county auxiliaries.

Memorial Service and Eulogies

Dr. Jacob S. Reisch, ISMS secretary-treasurer, conducted a memorial service at the opening session of the House of Delegates for the 155 deceased physician members and two staff members of ISMS, Mrs. Frances C. Zimmer and Mr. Timothy D. Selleck.

Dr. Charles J. Jannings, III, delivered a eulogy to Dr. L. T. Fruin, a man who "told it like it was." Despite the underlying frustrations and conflicts every doctor is confronted with, "Al was a physician filled with love, the kind of love that was patient and slow to anger . . . humble, considerate, and kind," Dr. Jannings said. President Fruin died one month prior to the convention.

At the opening session, three memorial resolutions were passed. The house extended its sympathies to the families of Dr. James B. Hartney, Former-ISMS Third District Trustee, Mrs. Zimmer and Mr. Selleck. Families of Dr. Hartney and Mr. Selleck were to be presented inscribed plaques on behalf of ISMS.

SAMA Cites MECO Project

Bruce Fagel, president of the Student American Medical Association, cited the MECO Project—in which ISMS physicians cooperated with SAMA in placing medical students into hospital orientation programs—as the greatest achievement of the group. In contrast, the lack of AMA cooperation provided the greatest disappointment, he reported. Mr. Fagel urged doctors to work with their peers in solving problems now before the medical society, so mem-

bers of his group and the future physician contingent will inherit respect due the profession.

\$186,175 AMA-ERF Check Presented To Illinois Medical Schools

President Charles J. Jannings, III, presented a check in the amount of \$186,175 to Dr. William Grove, executive dean of the University of Illinois College of Medicine, to be distributed among Illinois medical schools. The amounts designated are as follows:

Rush Medical College	\$9,309
University of Chicago	\$9,249
Pritzker School of Medicine	
Northwestern Medical School	\$22,789
University of Illinois	
College of Medicine	\$37,459
Chicago Medical School	\$17,909
Loyola University Stritch	
School of Medicine	\$26,709
Southern Illinois University	\$26,709
Others (Out-of-state)	\$39,135
Undesignated	\$23,347

Dean Grove thanked the Society in behalf of the Council of Medical School Deans in Illinois. He particularly impressed upon the House the importance of these contributions due to the cut in state funds by the Board of Higher Education.

Hamilton Teaching Award Presented To George Miller, M.D.

The Interstate Postgraduate Medical Association of North America presented its Hamilton Teaching Award to Dr. George Miller, Director



Dr. Merlin K. DuVal (r), Assistant Secretary of Health and Scientific Affairs in the Department of H.E.W. discusses his plans to encourage physician involvement in health care delivery with Willard C. Scrivner, Chairman of the Board of ISMS. Mrs. Alan Taylor of IMPAC is seen in the background.

of the Center for Educational Development, University of Illinois College of Medicine, for his outstanding contributions to medical education. Dr. Miller was the seventh recipient of the award, created in 1966 to recognize outstanding medical educators.

AMA Delegation Introduced

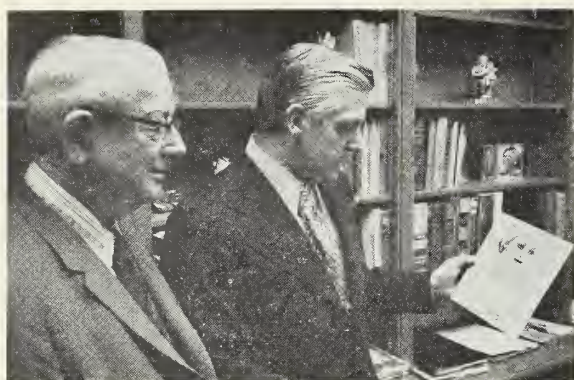
Dr. H. Close Hesseltine, chairman of the delegation, introduced the AMA delegates from ISMS: Drs. Carl E. Clark, Jack L. Gibbs, Theodore Grevas, Joseph Mallory, Morgan Meyer, Maurice Hoeltgen, Edward Piszczek, Harold Sofield, Philip Thomsen and Francis W. Young. Alternates introduced were Dr. Frank Jirka, Joseph O'Donnell, Fred Tworoger, T. R. Van Dellen, Herschel Browns, William Lees, George Shropshire, Paul Sunderland, Glen Tomlinson, John Ring, and C. K. Wells.

50-Year Club

Some 87 new members were inducted into the ISMS 50-Year Club at its annual luncheon, bringing the membership of this unique group to 601. More than 100 persons attended the luncheon and heard a discussion by Lee Fischer, National Treasurer of SAMA and senior medical student at the University of Illinois College of Medicine. Mr. Fischer reviewed changes in medical education over the past 50 years and paralleled today's education process to that of 1922 by citing the resurgence of the preceptorship and the MECO program.



Past presidents dinner honors living ISMS presidents. (Rear row, from left) Drs. J. E. Breed, Philip G. Thomsen, Edward Cannady, Edward Piszczek, Harlan English, Newton Du Puy, H. Close Hesseltine, and host J. E. Reisch, ISMS secretary-treasurer. Seated: (left to right) Leo P. A. Sweeny, George Lull, E. P. Coleman, Cesar Portes, and Arkell Vaughn.



Dr. Allison L. Burdick, Sr., recently inducted into the ISMS 50-Year Club and his son Dr. Allison L. Burdick, Jr. with 25 years of practice behind him look at photograph of the latter's daughter Suson who carries on the family's medical tradition. She teaches medical assistants in California.

President's Dinner

Tribute was paid to Dr. L. T. Fruin, our departed president, by presentation of an illuminated plaque and a scrapbook of his activities to his wife, Virginia. The event featured an outstanding string orchestra with choral selections by the Sing Out Oak Park group.

Duval Addresses Public Affairs Dinner

Over 250 physicians attended the Ninth Annual Public Affairs Dinner where they heard Dr. Merlin K. DuVal, Assistant Secretary of Health and Scientific Affairs in the department of H.E.W. Dr. DuVal encouraged physician involvement in providing health care and the planning of how it can best be delivered.

IMPAC's Role In Medicine and Legislation

Dr. V. P. Siegel, chairman, Illinois Medical Political Action Committee, reviewed IMPAC's role in government. He reported that doctors were involved in at least 10% of legislation this past year. His message for the coming year was for physician-members to become more actively involved in forthcoming elections by sending letters of endorsement to and by working for the candidates of their choice.

Medical Society's Busy Year in Review

Roger N. White, executive administrator of ISMS, briefly reviewed the effectiveness of the Society in getting things accomplished. He explained that until recently the physician's role had been that of provider of health care, but

the threat to the fee-for-service concept has changed that. This brought forth the establishment of an economic arm—a foundation for medical care—which was introduced during last year's Annual Meeting. It has since become a working plan. Mr. White described the foundation as "a mechanism for physicians to act rather than react."

In reviewing the financial affairs of the Medical Society, Mr. White pointed out that the economic situation demanded a review of the financial state of ISMS.

Foundation for Medical Care —One Year Later

Dr. Joseph O'Donnell, president of the IFMC, reviewed strides made by the Foundation since its conception one year ago. He briefly discussed the reasons for the Foundation and how it was initiated. HASP was developed by the Foundation and described as peer review and utilization review in purest form. Dr. O'Donnell reported an enrollment of 2,397 members in the Foundation with half the members from Downstate Illinois. A brief review of the structure and budget of HASP concluded his report.

Financial Matters

After hearing the Reference Committee on Finances, Budgets and Publications endorse a



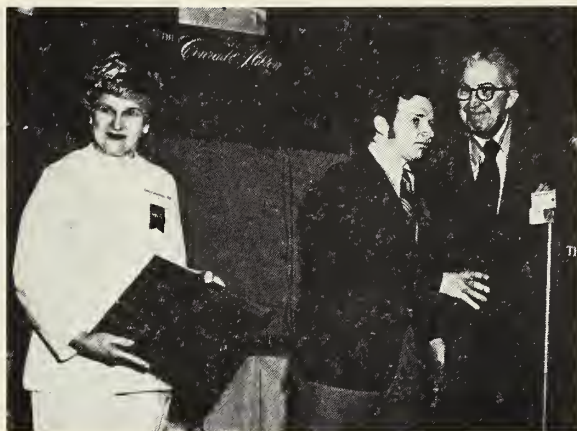
Dr. George Miller (l), Director of the Center for Educational Development, University of Illinois College of Medicine accepts the Hamilton Teaching Award from Dr. George R. Collohon. The award is presented by the Interstate Postgraduate Medical Association of North America for outstanding contributions to medical education.

membership dues increase, the House of Delegates accepted a Board of Trustees recommendation to increase dues by \$25 per year effective January 1, 1973. Encroaching inflation, a tremendous rise in the cost of doing business and the need to expand our socio-economic program were cited as the chief reasons for the increase. The last dues increase came in 1966. Since then, however, the cost of living has increased 24 percent as has the society's expenditures. For 1973 the dues will be \$130.

The \$4 special assessment to send ISMS materials to residents, interns and SAMA members was reduced to \$1, which will support activities geared to involving the emergent physicians in the affairs of professional medicine. These activities would include meetings with officers of student groups, publicity geared to interesting new physicians in ISMS membership, and support for local issue conferences. A new category of membership will allow students to join ISMS, at \$10 dues, which will entitle them to receive publications. Interns and residents also will pay \$10 in dues, an increase from \$2.

President Calls for Illinois Doctors To Act in Unity

Dr. Frank J. Jirka, Jr. was installed as president of the State Medical Society at the third session of the House of Delegates. President Charles J. Jannings III administered the oath

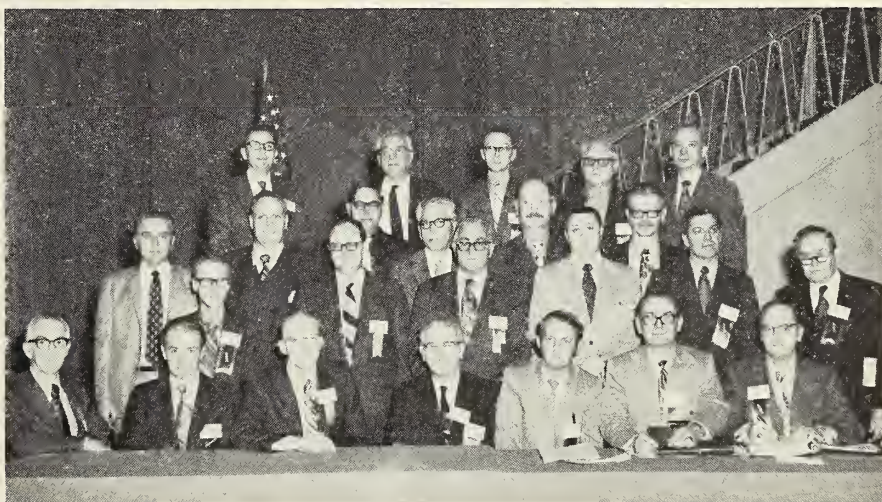


Mrs. Dorothy Buresh (l), "Moline Dispatch" and Mike McCabe (c), "Aurora Beacon News" accept ISMS Medical Journalism Fellowship plaques from Dr. Charles J. Weigel, Chairman, ISMS council on public relations.

of office and presented Dr. Jirka with the President's medallion. In his inaugural address, President Jirka called on the medical society to unify as health care designers . . . planners . . . and leaders, by supporting the state and county foundations, peer review and legislative programs. He concluded his remarks by urging the assembly to build the strongest organization they can and become the "doctors of our destiny."



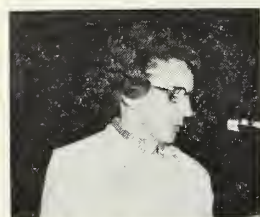
IMPAC chairman, Dr. V. P. Seigel, urges that House members become more involved in medical legislation by sending letters of endorsement to candidates of their choice.



New members of the House of Delegates assemble for the first time. (Sitting from the left) P. W. Sunderland, H.O.D. speaker, H. Frank Holman, David S. Helberg, Henry B. Okner, Hugh McMenamin, James W. Sunderland, Eugene L. Vickery. (2nd row) Eugene Pitts, Charles A. Ramey, George Markoutsas, Donald E. Hinderlitter, John S. Hipskind, Julian W. Buser. (3rd row) Rocco V. Lobraico, C. L. Flanagan, G. T. Wilkins, Erik Maran, James C. Parsons, Donald Edward. (4th row) R. G. Ryan, Charles Mrazek, Lee Johnson, Chester Thrift, Kenneth Kaufmann.

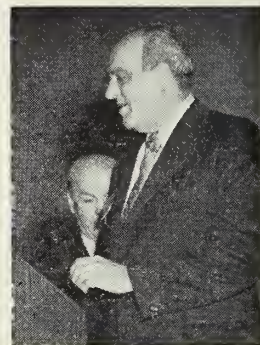


Mrs. David Kweder, president of the Woman's Auxiliary to ISMS, reviews the activities of the past year for the House of Delegates.



Miss Jean Berchinski, president of the Illinois Society, American Association of Medical Assistants, urges the House of Delegates to carefully consider a resolution which calls for ISMS support of legislation certifying physician assistants in Illinois.

Roger N. White, executive administrator of ISMS, receives an award for 12 years of service to the Illinois State Medical Society from Dr. Willard C. Scrivner.



Dr. Merlin K. DuVal (l), H.E.W. talks over program ideas with Mrs. Alan (Pam) Taylor of the ISMS Woman's Auxiliary during the convention.



Journalism Fellowship Awards

Mrs. Dorothy Buresh, of the *Moline Dispatch*, and Michael McCabe, of the *Aurora Beacon News* were presented plaques after completing the ISMS Journalism Fellowship program.

Executive Administrator Receives Recognition for Outstanding Service

Dr. Willard C. Scrivner, Chairman of the Board, presented Mr. Roger White, executive administrator of ISMS, with a certificate of appreciation in recognition of 12 years of exemplary service.

Reference Committee Chairmen

Serving the society as chairman of a reference committee were the following:

Constitution and BylawsC. P. Cunningham
Officers and AdministrationGeorge Alvary
Finances, Budgets and Publications

.....Herschel Browns
Governmental Affairs and Medical Legal

.....James P. Campbell
Education and ManpowerJohn S. Hyde
Environment, Community and

Mental HealthDavid T. Petty
Public Relations and

Miscellaneous Business ..Vincent C. Sarley

Economics, Peer Review,

Social ServicesRobert J. Becker

New Officers Elected for 1972-1973

The House of Delegates elected the following officers and Trustees:

President elect Willard C. Scrivner, Belleville

1st Vice President Joseph Skom, Chicago

2nd Vice President Glen Tomlinson, Lincoln

Secretary-Treasurer Jacob E. Reisch,

Springfield

Speaker of the House Paul W. Sunderland,

Gibson City

Vice Speaker Andrew J. Brislen, Chicago

Trustees elected were:

3rd District Eugene T. Hoban, Oak Park

3rd District Fredric D. Lake, Evanston

3rd District Warren W. Young, Crete

6th District Mather Pfeiffenberger, Alton

9th District Warren D. Tuttle, Harrisburg

10th District Herbert Dexheimer, Belleville

Dr. C. J. Jannings, III, will serve as Trustee-at-Large.

AMA Delegates and alternates, to serve from January 1, 1973 to December 31, 1974, were elected. Delegates: Drs. Carl E. Clark, H. Close Hesseltine, Maurice M. Hoeltgen, Joseph R. Mallory, and Theodore R. Van Dellen. Alternates: Frank J. Jirka, Jr., Jean Leonard, Fred A. Tworoger, Alfred Faber and John Ring.

Summary of Actions of the 1972 House of Delegates

I. AMENDMENTS TO CONSTITUTION AND BYLAWS

The House of Delegates amended the Society's bylaws to allow individual medical students to become ISMS members for the first time. To qualify for membership, a student must have been accepted for the second year or higher in an Illinois medical school and be a student member of a component medical society where provision has been made for this class of membership.

For the past two years, the Student American Medical Association, as an affiliated group, has elected one delegate and one alternate delegate for a single seat in the House. This representation will be maintained as student members of a county medical society will not be counted in that society's delegate strength, although the county society could elect to send a student as its delegate to the ISMS House.

In addition to students, the amended bylaws provide for eight other classifications of membership:

Regular

Provisional—for licensed physicians who are not U.S. citizens.

Associate—for unlicensed doctors holding hospital permits.

Emeritus—for physicians who are 70 and have been members of the Society 35 years.

Retired—for physicians no longer practicing medicine.

Service—for physicians in U.S. Government service or employed full-time by the AMA.

Distinguished—for prominent persons not eli-

gible for regular membership.

In-Training—for interns and residents.

Other major changes in the bylaws are:

1. Provision for the first and second vice-presidents and the vice-speaker to be voting members of the House of Delegates.

2. Substitution of the Sturgis Standard Code of Parliamentary Procedure (Current Edition) for Roberts Rules of Order of Business as a guide to procedure.

3. Reorganization of the Society's council and committee structure so that eight councils, four House of Delegates committees and eight Board of Trustees committees remain standing. All other committees will be eliminated by June 30, 1972, and will be replaced by ad hoc committees appointed to answer specific needs. The amended bylaws create:

a. COUNCILS—Medical-Legal, Governmental Affairs, Education and Manpower, Economics and Peer Review, Environmental and Community Health, Public Relations and Membership Services, Mental Health and Addiction, and Social and Medical Services.

b. HOUSE OF DELEGATES—Credentials, Rules and Order of Business, Tellers and Sergeants-at-Arms, and Changes in the Constitution and Bylaws.

c. BOARD OF TRUSTEES—Executive, Finance and Medical Benevolence, Policy, Ethical Relations, Committees, Constitution and Bylaws, Publications, and Advisory to the Woman's Auxiliary.

II. OFFICERS AND ADMINISTRATION

The House rejected a resolution calling for a search committee to be set up to recruit young and articulate physicians to serve as state society officers. The House supported a reference committee position that a search committee would not be a suitable vehicle to screen potential leaders, but the objective might be achieved if county and state societies would shorten commit-

tee tenure and eliminate multiple committee appointments.

A resolution to reorganize ISMS Trustee Districts to conform with the Governor's seven planning regions was not adopted. Instead, the House directed that an ad hoc committee be appointed to obtain sufficient information on the need for possible future redistricting and that this com-

mittee report its findings to the 1973 House of Delegates.

A resolution to abolish compulsory membership in the AMA was defeated.

III. FINANCES, BUDGETS AND PUBLICATIONS

The House directed the Society's administration to include an unaudited report of ISMS reserves in next year's Delegate's Handbook, if the audited report is not available and it requested this year's audited report be sent to all delegates as soon as it is ready. Because the annual meeting was advanced more than two months from its traditional May date, audited financial reports were not available in time for publication in the Handbook.

On recommendation of the Board of Trustees, the House voted to increase annual dues by \$25 and added a special assessment of \$1 per member to provide active liaison with students and new physicians. This activity will include regular meetings with officers of existing intern-resident organizations in Illinois, high-ranking ISMS officers and appropriate council members serv-

ing as advisors to SAMA; a publicity campaign aimed at interns and residents in Illinois to acquaint them with the activities of organized medicine; and participation in projects of interest to students and in-training physicians. In 1973 the following distribution of dues will be made:

Operating Fund	\$105
AMA-ERF	20
Benevolence	5
	<hr/>
	\$130
Special Assessment	1
	<hr/>
	\$131

Annual dues of \$10 were set for students and in-training members.

IV. ECONOMICS, PEER REVIEW, SOCIAL AND MEDICAL SERVICES

The following policies were adopted by the House:

1. Support of an amendment to drug labeling laws to allow physicians to give oral or written authorization to pharmacists not to identify contents—and to clarify the application of the drug labeling laws to dispensing physicians as well as pharmacists.

2. Endorsement of HASP as implemented by the Illinois Foundation for Medical Care, and commendation for the physicians and staff of the Foundation.

The House rejected a resolution to put ISMS on record as opposing cuts in general assistance funds. While sympathizing with the intent of the

resolution, the House said the basic problem of welfare funding is financial rather than medical. Also rejected was a proposal to put representatives of the consumers and the poor on all health policy decision-making boards. The reference committee stated that such representation already exists where it is valid, but consumers should not be called upon to make medical decisions. The House concurred.

The House referred to the Board of Trustees for study and appropriate action a substitute resolution concerning the release of fee profiles and actual charge data from third party payors to local peer review committees and foundations for medical care.

V. EDUCATION AND MANPOWER

The House adopted the following:

1. Support for State Boards of Examiners and opposition to the concept of national licensure of physicians.

2. Support for innovative programs in medical education.

3. Directs the ISMS delegation to the AMA to request the AMA to review its policy with regard to admitting foreign educated medical students to a year of supervised clinical training.

4. Petitions the Governor to recommend to the Illinois General Assembly that medical education be funded at the level approved by the Health Education Commission of the Illinois Board of Higher Education.

The House rejected a proposal to have ISMS support establishment of educational programs for professional nurse-midwives and the utilization of nurse-midwives in obstetrical programs and services.

VI. ENVIRONMENTAL, COMMUNITY AND MENTAL HEALTH

The House concurred with the Committee on Alcoholism that a 1971 resolution requiring mandatory hospitalization of alcoholics, referred for further study, be rejected.

Acting on another 1971 resolution referred for study, the House affirmed a desire to have all ambulance services meet minimum standards as soon as the statewide trauma network is fully implemented and that non-emergency transportation vehicles be used only for routine patient transfer and non-emergency medical transportation.

The House also adopted the following:

1. Until proof is available that Vitamin C is safe and effective in curing the common cold, ISMS members be informed the use of ascorbic acid for that purpose is not recommended.

2. That ISMS, through its Committee on Nutrition, inform the Director of the Illinois Department of Public Aid that it is on record as favoring the U.S. Department of Agriculture medium-cost plan for food allowances.

3. Endorsed the proper use of automated multiphasic health testing and screening laboratories and programs. An appropriate position statement, based on AMA guidelines, will be appended to the ISMS Policy manual.

4. Supported the Illinois Department of Public Health's efforts to identify undetected cases of venereal disease, especially gonorrhea.

5. That ISMS support only those medical programs, such as trauma centers or heart, cancer and stroke, which have appropriately involved physicians at the local level in the planning and development stages.

6. A directive to the ISMS Council on Governmental Affairs and the Council on Environmental and Community Health to study Dr. Vlado A. Getting's survey of public health conditions and needs in Illinois.

7. Referred to the Council on Mental Health and Addiction a resolution dealing with the use of special Illinois forms for the prescription of dangerous drugs.

VII. PUBLIC RELATIONS AND MISCELLANEOUS BUSINESS

The House rejected:

1. A resolution urging all members, including spokesmen for specialty societies, to refrain from publicly setting forth positions and policies which are in opposition to those adopted by local

county medical societies, ISMS or the AMA. (The House said this might be construed as a gag rule.)

2. A resolution relative to dues payments by service members on the grounds that such matters are covered by the new ISMS bylaws.

VIII. GOVERNMENTAL AFFAIRS—MEDICAL LEGAL

Following up a 1971 resolution calling for support of legislation eliminating contingency fees in malpractice suits, the House accepted the ongoing activities of the Governmental Affairs Council with respect to a series of bills on this subject as fulfilling the intent of previous action.

A resolution requesting ISMS to urge the AMA to form a Professional Rights Society composed of dentists, lawyers, etc., was referred to the Governmental Affairs Council for further study and subsequent recommendation to the ISMS Board of Trustees by May of this year.

While approving the concept of the primary

care physician's assistant, the House called for a one-year moratorium on enabling legislation. However, if enactment of such legislation appears imminent, ISMS should support Senate Bill 24, as amended, to provide that such assistants may work only under the supervision of physicians actively engaged in the private clinical practice of medicine.

Finally, the House approved a proposal to seek amendatory legislation to permit Blue Cross to pay for treatment in free-standing ambulatory medical and surgical facilities. Included in the action is a House-adopted definition of such facilities.

Actions on Resolutions

1972 House of Delegates

<i>Number</i>	<i>Introduced by:</i>	<i>Subject</i>	<i>Action</i>
72M-1	R. Hutchison for Medical-Legal Council	National Licensure for Physicians	Adopted
72M-2	L. Hirsch for Committee on Allied Health Education	Response to 71M-54 (Certification of Professional Nurse-Midwives)	Adopted
72M-3	Charles J. Jannings, III for Wayne Co.	Unified Voice of Organized Medicine	Rejected
72M-4	Charles K. Wells for Committee on Const. & Bylaws	Amendments to the Constitution	To be adopted in 1973
72M-5	Charles K. Wells for Committee on Const. & Bylaws	Amendments to the Bylaws	Adopted as amended by the reference Committee and the House
72M-6	Jack Gibbs for Council on Education & Manpower	Support for Innovative Programs in Medical Education	Adopted
72M-7	Herman Wing for Medical-Legal Council	Response to Resolution 71M-17 Malpractice Suits	Adopted
72M-8	Walter P. Plassman for Committee on Alcoholism	Action on 71M-12 Hospitalization of Alcoholics	Adopted
72M-9	James P. Campbell Committee on Public Safety	Response to 71M-32 Requirements for Ambulance Service	Adopted
72M-10	Eugene Diamond Nutrition Comm.	Vitamin C and Common Cold	Substitute Adopted
72M-11	Eugene Diamond Nutrition Comm.	Response to 71M-46 Support of Low Standard Budget	Substitute Adopted
72M-12	Edward Piszczek Environmental & Community Health	Policy on Automated Multiphasic Health Testing and Screening	Adopted as Amended
72M-13	Robert Hartman Maternal Welfare Committee	Professional Nurse-Midwife	Rejected
72M-14	Edward Piszczek Environmental & Community Health	Control of Venereal Disease	Adopted
72M-15	E. T. Leonard Winnebago Co.	ISMS Dues Exemption for Members over Age 70	Filed for Information
72M-16	E. T. Leonard Winnebago Co.	Equal Recognition for Military Service	Rejected
72M-17	E. T. Leonard Winnebago Co.	Commendation	Adopted
72M-18	Morgan Meyer Dupage County	Interprofessional Society for Sponsoring a Legal Rights Team	Referred to Governmental Council

72M-19	Morgan Meyer DuPage County	Appointment of Ad Hoc Search Committee	Rejected
72M-20	Robert Becker	Promotion of Public Health Care.	Adopted
(Revised) 72M-21	Will-Grundy David Lark	Financial Support of SAMA-MECO Project	Withdrawn
72M-22	David Lark Advisory to SAMA	Student Membership in ISMS	Adopted as Amended
72M-23	Jack Gibbs Education & Manpower	AMA Policy on Eligibility of Foreign Medical Stu- dents and Graduates for Admission to American Medical Education Support of SB 24	Adopted
72M-24	Jack Gibbs Ad Hoc Committee Physician Assistants		Substitute Adopted as Amended
72M-25	Alfred J. Faber CMS Delegate	Blue Cross Payments— Outpatient Surgical Facilities	Substitute Adopted as Amended
72M-26	James McDonald Kane County	Involvement of Local Physicians in Planning Stages of Statewide Medical Programs	Substitute Adopted
72M-27	Robert Stone Kane County	State Control of Dangerous Drugs	Substitute Adopted as Amended
72M-28	A. E. Livingston Ad Hoc Committee to meet with IPhA	Amendments to the Drug Labeling Laws	Adopted
72M-29	Kermit Mehlinger CMS Delegate	Opposition to Reduction in General Assistance Funds	Rejected
72M-30	Kermit Mehlinger CMS Delegate	Representation on Health Policy Boards	Rejected
72M-31	Jack Means Mason County	Re-organization of Trustee Districts	Substitute Adopted as Amended
72M-32	Charles J. Jannings, III	Funds for Medical Education	Substitute Adopted
72M-33	Robert Becker Will-Grundy	Guidelines for Charge Profiles	Substitute Amended and Referred to Board of Trustees for Study and Action
72M-34	Guy Pandola Will-Grundy	Reserve Funds and Audits	Adopted as Amended
72M-35	David Lark SAMA Delegate	Implementation of Emer- gency Health Personnel Act of 1970	Withdrawn
72M-36	David Lark Advisory Committee to SAMA	Support for Programs to Improve Liaison with Medical Students, Interns and Residents	Substitute Adopted as Amended
72M-37	W. W. Davidson Marion County	Compulsory Membership in AMA	Rejected
72M-38	Alfred Faber CMS Delegate	Illinois Foundation for Medical Care and the HASP Program	Substitute Adopted as Amended



editorials

AHA Competes with AMA in Health Care

We hear many rumors about how the American Hospital Association (AHA) soon will replace the American Medical Association as leader in the health care field.¹ Members of professional medicine may pass off the idea as an idle threat, but there is more to the rumored power struggle than meets the eye. It may even be too late to reverse this trend. Physicians have been too complacent during the past 20 years and their complacency has allowed hospitals and full-time medical personnel to get their foot in the door.

This is understandable considering the constant criticism of the way we have managed the care of our citizens. Meanwhile, the AMA's image has suffered as a result of internal strife, dwindling membership and diminishing revenues. And, during this period, we have witnessed the trend to institutionalize health services, making the hospital the center of health care in the community. More and more physicians have acquiesced to the demands of hospital boards and administrative officers (also members of AHA). In some areas, staff physicians also rent office space from the hospital. The number of full-time physician employees is also on the increase. The stage now is set to conform with one of many plans involving total health care. These manipulations quietly instituted have strengthened the position of the hospital.

Furthermore, we might add the boost that the AHA received from the political cry that our health system must assure every American access to quality health service. Washington set as its goal a complete overhaul of our health system. And, the AHA could easily claim that with its management talent and financial structure, this could be accomplished in an effective, organized and efficient manner.

Stephen M. Morris, the new AHA president, is quoted in *Medical News Report* as saying that "No one group of providers has all the power, all the political muscle, all the resources, nor all the wisdom to itself accomplish the tremendous job at hand . . . The AHA . . . is in a unique position to assume leadership of the movement (to revise the health system) and to help define and refine relationships between various health groups . . . We must begin publicly to assert our role as the principal spokesman not only for America's hospitals—but for all health care providers as well."

Morris' words should not be considered a declaration of war, but the AMA should give top priority to the challenge. As a democratic organization, the AMA has wasted valuable time and monies on trivia and defending its position. Apparently, we have failed to sell our government on the benefits of private practice, even though most people are satisfied with their physician. Or perhaps, the AMA with all its publications, bureaus, committees, and interrelationships with other organizations no longer serves the needs of the M.D. On the other hand, there is a better possibility that the M.D. no longer can survive by himself; it takes teamwork.

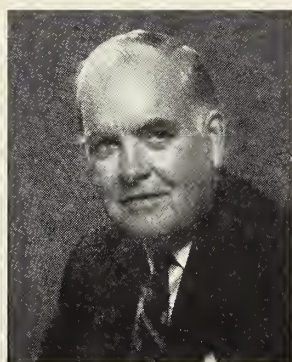
The AHA has accepted the diversity of interests within its system. The team includes MDs on medical staffs, nurses, technicians, administrators, medical students, and even the public, through boards of trustees. Conversely, the AMA has been reluctant to do this and even frowns on MDs not in active practice, excluding retirees. These "second rate" MDs are welcome as dues paying members, but that is all. Specialty so-

(Continued on page 506)

le

Maker of Medicine

Henry W. Gadsden,
Chairman & Chief Executive
Officer, Merck & Co., Inc.



In my opinion, it is the responsibility of all physicians and medical scientists to take whatever steps they think are desirable in a law- and regulation-making process that can have far-reaching impact on the practice of medicine. Yet many events in the recent past indicate that this is not happening. For example, it is apparent from drug efficacy studies that the NAS/NRC panels gave little consideration to the evidence that could have been provided by practicing physicians.

There are several current developments that should increase the concern of practicing physicians about drug regulatory affairs. One is the proliferation of malpractice claims and litigation. Another is the effort by government to establish the relative efficacy of drugs. This implies that if a physician prescribes a drug other than the "established" drug of choice, he may be accused of practicing something less than first-class medicine. It would come perilously close to federal direction of how medicine should be practiced.

In order to minimize this kind of arbitrary federal action, a way must be found to give practitioners both voice and represen-

tation in government affairs. Government must be caused to recognize the essentiality of seeking their views. One of the difficulties today, however, is that there is no way for concerned practitioners to participate in the early stages of decision-making processes. They usually don't hear about regulations until a proposal appears in the Federal Register, if then. By that time a lot of concrete has been poured, and a lot of boots are in the concrete.

Physicians in private practice, and particularly clinicians, should press for representation on the advisory committees of the Food and Drug Administration, joining with academic and teaching hospital physicians and scientists who are already serving. Though practitioners may not have access to all available information, the value of their clinical experience should be recognized. Clinicians, for example, rightly remind us that difficulty in *proving* precise effects does not necessarily mean a drug is ineffective.

Unless practitioners are more involved in drug regulations, it will be increasingly difficult for the pharmaceutical industry and scientists elsewhere to

make optimal progress in drug development. The benefit/risk ratio must be re-emphasized, and as part of this it must be acknowledged that benefit can come from the judgments of medical science as a whole. Even this concept, unfortunately, is not always accepted in drug regulatory processes. For example, if current medical opinion holds that an excess of total lipids and cholesterol in the blood is probably predisposing to atherosclerosis, and if a drug is discovered which reduces total lipids and cholesterol, the drug ought to be accepted *prima facie* as a contribution to medical science . . . until someone disproves the theory. The sponsor should not have to prove the theory as well as to develop and test the drug.

I feel a major new effort must also be made to erase the feeling of mistrust of medicine and of medicines

that seems to be growing in the public consciousness. Triggered primarily by strident announcements in Washington, people are reading and hearing confidence-shaking things almost continuously. Although challenge and awareness are essential to medical advancement, our long-term goal is constructively to build, not destroy. This means strengthening patient-physician relationships based on mutual confidence and trust. And in matters of health policy, it means working toward participatory rather than adversary proceedings—where everyone with an interest and a capacity to contribute has an opportunity to be heard . . . and, if that opportunity is not spontaneously afforded him, he may seek it.

Opinion & Dialogue

What is your opinion, doctor?

We would welcome your comments.



The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



practice management

Autos—To Lease or Not To Lease

FRANK PAWLOWSKI, CONSULTANT
PROFESSIONAL BUSINESS MANAGEMENT, INC.
67 EAST MADISON STREET, CHICAGO, ILLINOIS
782-2282

With the increasing availability of auto leasing companies, medical people are beginning to consider if it might not be advisable to lease an automobile as an alternative to buying one.

The critical point of this question would be the comparative figures of ownership vs. leasing costs. The leasing industry deemphasizes this point, but concentrates rather on the service and convenience. The comparison will usually indicate that leasing prices are neither materially cheaper nor costlier than ownership, but that there is a positive reduction in worry, frustration, and record-keeping.

The proponents of car leasing cite the following list as the primary advantages to the lessee:

- a) Leasing leaves capital free for other purposes.
- b) Cash is not frozen in fixed assets and can be used for investments or some other better use.
- c) Such investments might be a hedge against inflation.
- d) Autos leased for business use provide a tax deduction.
- e) Additional bookkeeping records of depreciation schedules, upkeep and insurance costs, etc. are eliminated.
- f) No cash outlays are necessary for license plates, inspection fees, and possibly insurance.

- g) Certainly the most attractive facet of all the advantages is that one can contract to have the lessor pay all costs of maintenance, with another car furnished during repair work, even where the lessee is at fault.

What are the costs of leasing? Undoubtedly you will find various prices quoted in the advertising sections of newspapers. You pay more for a prestige car than for an economy model and more for a full-maintenance contract than a simple rental. A 24-month lease is cheaper per month than a 6-month or a 1-year contract. Ads can be found offering an Oldsmobile Holiday 88 or a Buick LeSabre on a one-year term for \$190.00 per month and \$150.00 a month on a 2-year lease; a Cadillac Coupe Deville for \$210.00 per month for 1 year or \$183.00 per month for a 24-month contract.

Under the terms of all leases, whether full-maintenance or without maintenance, the lessee pays for gasoline and toll charges and parking fees plus a surcharge over a maximum annual mileage allowance of possibly 30,000 miles in most leases.

However, the one major factor in assessing the leasing costs would be the quality and availability of service offered by the leasing company. Some companies give around-the-clock service while others close their service garages on weekends and holidays.

(Continued on page 506)

Obituaries

****Asche, Walter F.**, Chicago, died Mar. 18, at the age of 78. He served on the staffs of several Chicago hospitals. He was a physician for more than 50 years.

***Bliss, Jacob E.**, Chicago, died Mar. 15, at the age of 65. He has been on the staff of St. Elizabeth's Henrotin and Roosevelt Memorial Hospitals for the last four decades.

***Hanley, D. Reed**, Streator, died Mar. 3, at the age of 68. He was radiologist at Fairbury Hospital from 1956 to 1969, at St. James Hospital in Pontiac from 1948 to 1958 and had practiced at Streator and La Salle Hospitals. He also worked at General Hospital in Ottawa.

****Hedges, Walter Vincent**, Frankfort, died Mar. 9, at the age of 86. He is a fellow in the American College of Surgeons and a former chief of staff at Silver Cross Hospital. He has founded the Hedges Clinic and he was a physician for more than 50 years.

***Hillebrand, John George**, River Forest, died Sept. 17, at the age of 66. He was affiliated with St. Mary of Nazareth Hospital.

***Javois, Alexander J.**, Palm Beach, died Mar. 28, at the age of 72. Before his retirement he was chief of staff at Holy Cross Hospital and associated with Mercy Hospital.

****Manougian, Kirkore M.**, Elgin, died Mar. 15, at the age of 90. He was appointed as a senior physician and surgeon at the State Hospital, Dunning, Illinois and latter was a clinical pathologist at the State Psychopathis Institute at Kankakee. He was also director of the Resthaven Sanitarium, Elgin. Dr. Manougian was the secretary of the Kane County Medical Society and was a staff member of Sherman and St. Joseph Hospitals.

***Mickow, Albert**, Chicago, died Dec. 7, at the age of 73.

Niblack, Henry Clay, Springfield, died Nov. 24, at the age of 84.

***Pearce, Lee J.**, Eldorado, died Mar. 8, at the age of 69. He assumed the practice of his father and constructed the new Pearce Hospital in 1950.

***Romanski, Arthur F.**, Berwyn, died Mar. 29. He was a staff member of the MacNeal Memorial Hospital and associate of St. Mary of Nazareth Hospital.

****Schwartz, Otto**, Chicago, died Mar. 20, at the age of 88. He held offices for many years

at Illinois Masonic Medical Center where he was past president of the staff. He was also a physician for more than 50 years.

***Scott, Jordan J.**, Chicago, died April 1, at the age of 49. He served as treasurer of the medical staff at St. Francis Xavier Cabrini Hospital.

***Serritella, Rocco V.**, Oak Park, died Feb. 24, at the age of 57. He was a well-known urologist, at Cook County Hospital. He was also on the staff at Loretta, Gottlieb, Northlake Hospitals.

***Shellow, Harold**, Chicago, died Nov. 23, at the age of 67. He was on the faculty of his alma mater and served on the staffs of the University of Illinois Research and Educational and Henrotin Hospitals.

Simer, Parke, Elmhurst, died Mar. 6, at the age of 74. He was a professor for many years at the University of Illinois College of Medicine. Previously he was on the faculty of Illinois Wesleyan University, Bloomington.

***Slakis, Susan A.**, Homewood, died Nov. 7, at the age of 83. He served as director of the Lincoln State School.

***Sokol, J. Kenneth**, Evanston, died Mar. 20, at the age of 60. He was on the staff at Wesley Memorial Hospital and a member of the Northwestern University Medical School faculty. He was a former president of the Chicago Urological Society.

***Stenn, Arthur**, Chicago, died Nov. 10, at the age of 67. He was a physician for many years for the Cook County Department of Public Aid.

***Tan, Yan Ping**, Oak Lawn, died Feb. 26, at the age of 43. He was a physician at the Stickney Township Medical Center and associated with the Oak Forest Hospital infirmary.

***Tobin, Walter W.**, died Mar. 25, at the age of 66. He practiced in Chicago and Elgin. He taught dermatology in Rush Medical School, the University of Illinois Medical College and Cook County Hospital.

Van Dellen, R. L., Michigan, the father of Dr. Theodore R. Van Dellen, the editor of the *Illinois Medical Journal*, died April 8, at Mercy Hospital, in Benton Harbor, Mich.

***Wicks, Mark**, Chicago, died April 2. He maintained an office and was on the staff of Augustana Hospital for 30 years.

**Denotes member of ISMS*

***Denotes member of 50-Year Club*

When you prescribed Orinase[®] (tolbutamide, Upjohn) 14 years ago, you had to rely on our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated fetotoxic and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions; not to develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the treatment period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limitations of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the physician.

Today you have your own.

If you're around 40 or 45, you've probably had quite a bit of clinical experience with Orinase.

Maybe as much as 14 years.

And that means you know quite a bit about it.

On the one hand, you know that diet and weight control are the initial and essential foundations for the management of adult-onset, non-ketotic diabetes. When these measures prove satisfactory, no additional therapy is indicated. On the other hand, you know now that if these measures fail the addition

of Orinase to the regimen can often help lower blood sugar. Orinase lowers blood sugar as effectively today as it did when you first prescribed it.

You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

In short, Orinase is a drug you're familiar with, and probably have confidence in.

And that may be the best recommendation Orinase can have.

Orinase® 0.5 g. tablets (tolbutamide, Upjohn)

can daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenylramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without pro-

ducing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

Supplied: 0.5 g. Tablets—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

For additional product information, see your Upjohn representative or consult the package insert.

The Upjohn Company, Kalamazoo, Michigan 49001

Upjohn

© 1971 The Upjohn Company JA71-1495 MEDB-5-S LAO-6

Touring Europe

(Continued from page 473)

hours were lost due to illness. Three players had to leave the tour on account of sudden illness in their families, state side, but were able to rejoin the tour. Figure I summarizes the illnesses treated during the trip. They do not include the many consultations held on planes, buses, in restaurants and concert halls.

Figure I

Office Visits Orchestra Members	201
Non-Playing Personnel (Wives, Children, Management)	76
Total Office Visits	277
House Calls	8
Hospital Visits	5
Surgery—Repair of Ruptured Right Quadriceps Femoris Muscle.	
Upper Respiratory Infections predominated.	
Diabetic Patients	2
Gastro-Intestinal complaints were second in frequency. These included mostly Gastro-Enteritis.	
Tendonitis (tennis elbow)	5
Appeared uncommonly. Occupational hazard amongst violinists. 4 cases had Steroid injections with good results.	
Cardio-Vascular Disease and Hypertension	
Bilateral Cervical Lymph Adenopathy—Bilateral Axilla and Groin. Suspect Lymphoma or Metastases. Advised to have Excision Biopsy. Refused. Continued with tour. X-ray and Blood Count normal. Clinically did not have temperature, chills, fever, sweats, weight loss.	
Genito-Urinary—several cases of Cystitis.	
Anxieties, Insomnia, frequently seen.	
Several minor injuries also were attended.	
Miscellaneous complaints not easily classified.	

I feel that the constant availability, accessibility, presence, and regular daily office hours prevented any illness to progress beyond its incipency. The orchestra personnel felt confident and secure about their health. In a way it contributed to the stellar performances.

As a physician-musician non-playing member of the group, I hope to have contributed in my way to the great success of the European 1971 Chicago Symphony Orchestra Tour. ◀

Philip Kaplan, M.D., F.I.C.S., is attending surgeon at the Edgewater Hospital. He received his B.S. in 1929 and M.D. from the University of Illinois in 1931. He served his internship at Cook County Hospital from 1931-1933 and his residency in pathology from 1933-1935.



Critically Injured

(Continued from page 478)

in any patient with trauma. X-rays should be used liberally but judiciously. There are few X-rays that will substitute for a thorough clinical evaluation. All suspect fractures should be evaluated. A chest X-ray is taken after any thoracic trauma. Abdominal films are of less value but may be helpful in locating a retained missile. The presence of hematuria demands an intravenous pyelogram and cystogram. Arteriography is helpful in the management of arterial injuries and splenic and renal trauma.¹⁰

It is important to remember that most X-ray departments provide little if any clinical observation or critical patient care.

XI. Special Studies

Patients with suspect abdominal trauma should have a paracentesis performed. Emergency thoracentesis and pericardiocentesis are both diagnostic and therapeutic when indicated. The echoencephalogram is finding increased usage in the rapid screening of patients with possible cerebral injuries.¹¹ Bronchoscopy should be performed on all patients with evidence of tracheal or major bronchial injury. Esophagoscopy is useful in penetrating neck wounds. Proctoscopy must be done on patients with suspect rectal trauma.

Summary

1. The Illinois Statewide Trauma Care Program is addressing its program activities to the training and education of all health professionals involved with the care of the critically injured.

2. To facilitate the communication between all members of the critical care health team a Critical Injury Index has been developed. This index is a listing of the ten most important features of serious injury, described in non-medical terms. These are descriptive findings only, and not intended as diagnoses.

3. An overview of the initial management of the critically injured patient has been outlined which will provide a basic approach for those involved with the care of the victims of major trauma. ◀

(Continued on page 507)

what goes on

a guide to continuing education

May 15-17—Committee on Adult Education of the American Academy of Orthopaedic Surgeons

Surgery of the Adult Foot

The program will include symposiums on injuries to the ankle and foot, neurovascular influences on wound healing, and prosthetic-orthotic need.

Registration fee: Physicians \$150, residents and allied health personnel \$50.

Contact: American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Ill. 40611

Sheraton-Chicago, Chicago

May 15-19—The Roosevelt Hospital

Theoretical background and practical handling of allergic problems.

Included in the session topics will be immunology, skin tests, asthma therapy, cellular reactions and mold allergies. Fee \$100.

Contact: Marcelle M. Johnson, Administrative Manager, 428 W. 59th St., New York, NY 10019.

The Roosevelt Hospital, New York, N.Y.

May 15-19—Harvard Medical School

Pediatrics

The course will present an intensive, panoramic survey of recent advances in preventive, diagnostic, and therapeutic pediatrics designed for physicians who care for infants, children, and adolescents.

Fee: \$200.

Contact: Department of Continuing Education, Harvard Medical School, 25 Shattuck St., Boston, Mass. 02115.

Massachusetts General Hospital, Boston.

May 17-18—University of Cincinnati

Recent Advances in Abdominal Surgery

This program is designed primarily for general surgeons and will cover topics on recent advances in surgery relating to abdominal sepsis, lesions and the colon and rectum, penetrating and nonpenetrating wounds of the abdomen, disease of the liver and biliary tract, and endocrine and non-endocrine producing tumors of the pancreas. The course is given under the auspices of the Department of Surgery and Command of the University of Cincinnati by members of the faculty and a panel of guest lecturers of international renown. There will be ample opportunities for questions from the audience.

Fee: \$70.00

\$30.00 Residents

Contact: Office of Conman, 114 Medical College Building, Eden & Bethesda Avenues, Cincinnati, Ohio 45219 or Phone 513-872-5681.

May 17-19—College of Physicians and Surgeons, Columbia University

Use of Psychotherapeutic Drugs in the Treatment of Mental Illness

Purpose of the course is to provide physicians with clinically useful information on psychotherapeutic drugs and their uses. Principal means of providing this information will be a series of lectures by a group of nationally eminent physicians and scientists.

Registration fee: For practicing physicians \$150, for residents \$75.

Contact: Dr. Lance R. Simpson, Director, College of Physicians and Surgeons, Columbia University, 630 W. 168 St., New York, NY 10032.

Alumni Auditorium, Columbia University, New York.

May 19—University of Cincinnati College of Medicine

"Organic Brain Disease & Pathologic Speech"

This program will include material concerning the patient with cerebral vascular accident and other central nervous system diseases. Fee: \$20.00 (Includes lunch). Medical students—free if space is available in auditorium. Limited registration. Please contact: Of-

Office of CONMED, Room 114 Medical College Bldg.,
Eden & Bethesda Avenues, Cincinnati, Ohio 45219.

**May 22-25—International Childbirth
Education Association**

"This Child: The Quality of Life"

Subjects to be covered at the convention include: Early family behaviour, development of the infant personality, breastfeeding, family centered maternity care, new developments in childbirth education, infant outcome and maternal medication, nutrition, and parent effectiveness training.

Non-ICEA members can register for the convention. Information and registration materials are available by writing to ICEA Convention, 11420 W. Belmar Dr., Hales Corners, Wis. 53130.

Pfister Hotel, Milwaukee, Wisconsin

May 24—Illinois Masonic Medical Center
"Precancerous and Potentially Malignant Oral Lesions"

Contact: Illinois Masonic Medical Center, Dept. of Dentistry, Section on Continuing Education, 923 W. Wellington, Chicago, Ill. 60657.

May 24-26—American College of Physicians
Progress in Nephrology

Program will include review of the present state of the art in renal physiology, pathology, physiology, pertinent pharmacology, and clinical aspects of renal disease.

Registration fee: ACP members, FACP and residents and research fellows \$80, nonmembers \$125, and associates \$40.

Contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St. Philadelphia, PA 19104.

George Washington University Hospital,
Washington, D.C.

**May 25—University of Cincinnati College
of Medicine**

"Current Concepts in Endocrinology"

Fee: \$20 (Includes lunch).

Please contact: Office of CONMED, Room 114 Medical College Bldg., Eden & Bethesda Avenues, Cincinnati, Ohio 45219.

**May 25-27—The Illinois Society of
Anesthesiologists**

"Regional Anesthesia"

Conrad Hilton Hotel, Chicago

**June 7-9—Central Illinois, Alpha, North-
western Chapters A.A.I.T. and the Illinois
Tuberculosis and Respiratory Disease
Association**

The Third Annual Illinois State Seminar

Some Topics are: Malpractice, Rehabilitation, Education, Role of the Medical Director, Pulmonary Function Interpretation and other important Subjects.

For further information contact: Mr. Ed Green A.R.I.T., Springfield Memorial Hospital, First and Miller Street, Department of Inhalation Therapy, Springfield, Illinois 62701.

Holiday Inn East, Springfield

**June 14-16—American Academy of
Orthopaedic Surgeons Committee
on Injuries**

*An Advanced Practical Course—Emergency
Care and Transportation of the Injured
and Sick.*

There will be lectures, demonstrations, discussions and class participation. Concerning: Anatomy and Physiology, Surveying the Injured, Life-Threatening Emergencies, Care and Complications of Injuries, Environmental Hazards, Medical Emergencies, The Disturbed and Unruly Patient, Emergency Childbirth, Rescue and Extrication and Transportation and Communication.

Advanced registration before June 1 is requested. Tuition Fee is \$50.00. For further information contact Dan J. Scott, MD, 188 Bellevue Blvd. Suite 101, Memphis, Tennessee 38104.

Wassell Randolph Student Center, University
of Tennessee.

**June 17—The Council on Health Manpower—
American Medical Association**

Bringing People and Services Together

To assess the extent of geographic and specialty manpower maldistribution in relation to health service needs. To critically examine approaches to alleviation and to chart new directions for action at national, state and community levels.

Pre-Registration and additional information may be obtained by contacting the AMA Department of Health Manpower, 535 N. Dearborn Street, Chicago, Illinois 60610.

**June 18-22—The American Medical
Association**

121st Annual Convention

To insure your AMA accommodations contact the AMA Housing Bureau c/o San Francisco Convention Bureau, 260 Fox Plaza, San Francisco.



Auxiliary urges fight on pollution

MRS. ROBERT HART, PULSE EDITOR



The March Convention was honored to have in attendance the State Auxiliary's first President (1927-1929), Mrs. G. Henry Mundt, shown with newly sworn in President Mrs. August Martinucci.

"Plant Don't Pollute"

AS WE'RE SCURRYING about making plans for the Spring that's upon us and the Summer months ahead, Mrs. W. H. Schowengerdt, Chairman of the Rural-Urban Health Committee, gives us a timely reminder when she states:

"Almost every product you use creates some sort of pollution. Living plants are the only exception since they constantly increase in size and beauty to fight pollution and help eliminate the problem.

Living plants act as noise and sound barriers. They also filter dust particles from the air. Plants are quiet, efficient, and beautiful. They have no moving parts, yet their leaves take in carbon dioxide and worse atmospheric pollutants—sulfur dioxide, ozone, hydrogen, fluoride, etc.—and in return give out pure oxygen. The sturdier the plant, the more the purification.

Do your part to fight pollution and beautify our environment!"

"Plan A June Trip Westward"

Mrs. G. Prentiss Lee, President WA/AMA, extends a warm western welcome to all auxiliary members to attend what will be a memorable occasion, the 50th Anniversary Convention in glamorous, cosmopolitan San Francisco, California, June 18-22, 1972.

The social events this year are especially exciting and will emphasize youth and family interests, including:

- A Boat Cruise of San Francisco Bay
- Tours of the old sailing ship *Balclutha* and the wax museum
- A visit to Frontier Village Amusement Park
- Marine World on San Francisco Bay
- A NAPA Valley Wine Tour
- A Style Show Featuring Oriental Fashions
- Program speakers Art Linkletter, and Dr. Edward Stainbrook, Chairman, Dept. of Human Behavior, USC School of Medicine

Headquarters for the Convention will be in the elegant "new" St. Francis Hotel looking out over Union Square, where a block of rooms has been set aside for the auxiliary. Reservation forms will be found in *MD's Wife*.

HEARD AT CONVENTION . . .

● "Your community is a whole lot happier, more knowledgeable, and healthier because you cared enough to make it so!" —Adele Kweder, Past Pres.

● "One auxiliary member on her feet is worth two on her seat!" —JoAnne Richardson, President, Peoria County.

Morgan-Scott County Auxiliary is growing. With their five new members, they now total twenty members, who have concentrated on raising funds for AMA-ERF and contributing to Project Hope and the Benevolence Fund.

the view box

(Continued from page 459)

DIAGNOSIS: *Rheumatoid Arthritis of the Elbow Joint*—The outstanding feature of the film is an osteolytic lesion in the head of the ulna. A careful inspection also demonstrates considerable soft tissue swelling about the elbow joint, in addition the AP and oblique view reveals narrowing of the joint itself with osteoporosis which is juxta articular in character. The lesion is the so-called rheumatoid pseudocyst which is really an extension of the synovial lesion into the cortex of bone and at surgery, a definite connection to the synovial tissue can usually be demonstrated. These people also have a tendency to be soft tissue nodule formers as well. The patient had diffuse rheumatoid arthritic changes with marked deformities of the hands, wrists and feet. The lesion is presented because of its interesting differential possibilities when seen as a solitary lesion without additional history.

ekg of the month

(Continued from page 463)

ANSWERS:

- A) 1,3,4,5, The axis is -75° , and there is intraventricular conduction delay of 0.13 seconds with a terminal S wave in I and V_6 , and an rsR' in V_1 , indicating RBBB. Lead II illustrates high degree A-V block, the second QRS being a capture beat. Trifascicular block is implied by the combination of RBBB, LAD (left anterior hemiblock), and evidence of A-V block (caused by partial or complete block of the remaining inferior fascicle of the left bundle branch.)
- B) 2,3 Syncope is frequently caused by complete heart block because of fall in cardiac output. The combination of syncope and this type of conduction abnormality should be treated with a pacemaker.

Autos—To Lease

(Continued from page 498)

If you have become convinced that leasing is to your advantage, before entering into any contractual agreements, it is best to first check with either your local Chamber of Commerce, local automobile club, or the Better Business Bureau, and your attorney.

In our work of assisting doctors on the busi-

ness side of their practices, we have reviewed numerous lease proposals. Seldom are the costs of leasing prohibitively expensive, but on the other hand we are not convinced that ordinarily a doctor should lease his business automobile on a regular basis as compared to purchasing. Capital preservation and the maintenance contract, as the primary advantages of leasing, seldom are a major consideration to the average doctor. The ordinary medical person is engaged in a service business which requires a minimum of capital. Also maintenance generally is not an important factor to a doctor, because of new car warranties, a second family car, leasing availability, and the ability to finance auto repairs.

Even though leasing involves yet another middleman between manufacturer and user, the additional cost of leasing is not so expensive after taxes that a doctor should refuse to try it. We advise our clients to use one of the leasing plans if they believe it serves their particular purpose.

AHA Competes with AMA

(Continued from page 494)

cieties have also hurt the AMA and now that family physicians are well organized, a change in policy may be in order. The strength of the AMA lies in its state and local medical societies and Dearborn Street should never forget it. This may be the time to update the structure of the AMA so that it will also function as an "umbrella organization" capable of influencing all elements of the health care system.

A union might be the answer for the physician who expects to work part or full-time for the government, hospital, clinic, industry, or a third party group. In dealing with employers, he may need representation by a collective bargaining unit—something repulsive to many physicians. By law, the AMA cannot unionize. There is a movement of house staff associations toward the formation of unions, but they are having some difficulties. The Physician's Health Congress in California is having more success representing a group of office practicing physicians. Your medical society is well aware of the need for group participation in the socioeconomic aspects of medicine, because it is becoming more difficult for the private physician to survive as an isolated island unto himself.

T. R. Van Dellen, M.D.
Editor

J. Medical News Report

WHO Fellowships Available to U.S. Health Workers

The World Health Organization will make available in 1973 a limited number of short-term fellowships for travel abroad related to the "improvement and expansion of health services" in the United States. This support is to United States citizens engaged in operational or educational aspects of public health.

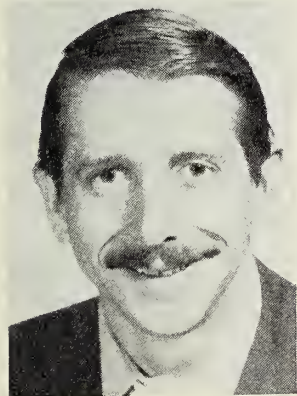
Further information may be obtained from Dr. Robert W. Jones, III, Chief, Foreign Students Education Branch, Fogarty International Center, National Institutes of Health, Room B2C05A, Building 31, Bethesda, Maryland 20014.

San Francisco AMA Meeting

Are you planning to attend the AMA Meeting in San Francisco, June 18-22, 1972? The ISMS has arranged for group travel on June 16, departing at 4:15 p.m., and June 17, departing at 11:00 a.m. from O'Hare International Airport. The price round trip will be \$197.20, including one way transfer from the Airport to the Hotel. We have left the return flight open so you may return at your own convenience. If you wish flight accommodations specify flight and send a check for \$25.00 per person payable to ISMS to Perry L. Smithers or Betty Lynch Duffy, ISMS, 360 N. Michigan, Chicago 60601 (312-782-1654).

Headquarters Office Business Manager

Mr. Richard D. Hengl has recently joined the ISMS headquarters office staff to fill the position of Business Manager. He was formerly employed as a Branch Manager for Klockner-Moeller, Inc., and by Spencer-MacLennan Auditing.



A graduate of Coe College, Cedar Rapids, Iowa, Mr. Hengl resides in Arlington Heights with his wife, Gail, and two-year-old daughter Katie Elizabeth. He is a native of Chicago.

In his new assignment, Mr. Hengl will be responsible for the day to day operations of ISMS headquarters with respect to fiscal matters. He will also assist the IFMC in setting up its business office functions.

Mrs. Robert (Sandie) Koelbel, who has been on staff for over ten years and has been business manager, is leaving for maternity reasons.

Initial Care

(Continued from page 502)

References

1. Flashner, B. A., Boyd, D. R.: The Critically Injured Plan: a plan for organization of a statewide system of trauma facilities, *Illinois Medical Journal* 139:256-265, March, 1971.
2. Boyd, D. R., Mains, K. D., Flashner, B. A.: Status report: Illinois statewide trauma care system, *Illinois Medical Journal* 141:56-62, Jan., 1972.
3. Boyd, D. R., Editor: The Emergency Medical Technician-Ambulance, *Trauma Newsletter* Vol. 1 No. 3, Jan., 1972.
4. Boyd, D. R., Editor: The Trauma Nurse Training Program, *Trauma Newsletter* Vol. 1 No. 4, Feb., 1972.
5. Baker, R. J., Boyd, D. R., and Condon, R. E.: Priority of Management of Patients with Multiple Injuries, *Surg. Clin. No. Amer.* 50:3-11, 1970.
6. Stahl, William: Resuscitation in Trauma: the value of central venous pressure monitoring, *J. Trauma* 5:200-212, 1965.
7. Boyd, D. R.: Open wounds, *Emergency Medicine* 3:100-105, 107, 109, 113-114, 119-120, Sept., 1971.
8. Boyd, D. R., Addis, H. M., Chilimindris, C., Lowe, R. J., Folk, F. A., and Baker, R. J.: Utilization of osmometry in critically ill surgical patients, *Archives of Surgery* 102:363-372, April, 1971.
9. Attar, S., Boyd, D. R., Layne, E., McLaughlin, J., Mansberger, A. R., and Cowley, R. A.: Alterations in coagulation and fibrinolytic mechanisms in acute trauma, *J. Trauma* 9:939-965, 1969.
10. Freeark, R. J.: Role of Angiography in the Management of Multiple Injuries, *Surg., Gynec., Obst.*, 128: 761-771, 1969.
11. Leksell, L.: Echoencephalography. II Midline echo from the pineal body as an index of pineal displacement, *Acta Chir. Scand.* 115:255, 1958.

Skin Manifestations

(Continued from page 462)

5. Benedek, Tibor: *Military dermatology in general hospitals in the zone of the Interior and in the Pacific Ocean Area in World War II*. Based on observations of 6,683 consecutive cases. *Urol & Cutan, Re.* 52:160-174, 1948.
6. Benedek, Tibor: "Skin manifestations of hypovitaminosis A," *International Rev. of Vitamin-Research*, 30:10-36, 1959.
7. Thiers, H.: *Les Vitamines*. Masson & Cie, Paris, 1956.
8. See references under 6.
9. Plewig, G.: "Topical treatment of acne vulgaris," *Pennsylvania Medicine*, 72:33-36, 1969.
10. Lazar, P. et al.: "Demethylchlortetracycline hydrochloride and nephrogenic diabetes insipidus," *Cutis*, 6:881-883, 1970.
11. Kligman, A. M.: "Questions and answers: A discussion on acne," *J.A.M. Women's A.* 24:295-296, 1969.
12. Josephs, H. W.: "Hypervitaminosis A and carotene-mia," *Am. J. Dis. Child*, 67:33, 1944.
13. Knudson, A. G. & Rothman, P. E.: "Hypervitaminosis A," *Am. J. Dis. Child*, 85:316-334, 1953.
14. Oliver, Jr., Th. K.: "Chronic Vitamin A intoxication," *Am. J. Dis. Child*, 95:57-68, 1958.



HOME HEALTH CARE Is Our Specialty

DOCTOR: A MEDICAL EQUIPMENT UNLIMITED Pharmacy can provide the essentials needed to assist your patient in home convalescence or extended care. We deliver all items your patients require to their home on a sales or rental basis.

The following are some of the major items stocked: Convalescent Aids; walkers, wheel chairs, commodes, assist rails, canes, crutches. Orthopedic Equipment; back braces, trusses. Elastic Goods; compression hosiery, (custom fitted and custom made). Incontinent Aids; Exercise equipment, Inhalation equipment, Hospital beds, Colostomy, Osteotomy needs. WE INVITE YOU to investigate the services of an MEU Pharmacy by calling one of the following in your area:

CHICAGO

Adams-Woods Pharmacy
5258 West Fullerton
(237-0342)
Braun Pharmacy
2075 Lincoln Avenue
(LI-9-0634)
Bruce & Ken's Pharmacy
7150 West Addison
(685-6300)
Dodge Drug
3235 West 111th Street
(238-6686)
Elsdon Medical Pharmacy
4258 West 55th Street
(LU-2-2660)
Harry Ose Pharmacy
157 West 119th Street
(785-3984)
Lee Lincoln Pharmacy
6193 Lincoln Avenue
(539-1015)
Medical Care Pharmacy
2958 South Wallace
(225-6080)
P. F. Swanson Pharmacy
5259 North Clark Street
(LO-1-3222)

BERWYN

Havranek Pharmacy
6843 West Cermak Rd.
(ST-8-0175)

BROOKFIELD

Lonhart Pharmacy
9046 West 31st St.
(HU-5-2420)

DES PLAINES

Maple Pharmacy
1798 Oakton
(824-6191)

DOWNERS GROVE

Cameo Pharmacy
2752 Maple Avenue
(964-3784)

ELGIN

Munch's Civic Center Pharmacy
101 Douglas
(742-4277)

HOMEWOOD

Niebert Pharmacy
2053 Ridge Road
(799-8552)

MOUNT PROSPECT

Van Driel's Pharmacy
100 East Northwest Highway
(CL-3-6494)

PARK FOREST

Needhams Pharmacy
23450 South Western Avenue
(747-0244)

ROCKFORD

Nowicki Pharmacy
1414 North Main
(815-962-4071)

WESTCHESTER

Nosek Apothecary
1925 Mannheim Road
(865-8900)

WESTMONT

Westmont Pharmacy
2 North Cass
(WO-9-2043)

WINNETKA

Conney Pharmacy
736 Elm Street
(446-3335)

WHEATON

Hawthorne Pharmacy
1425 N. Main Street
(MO-8-7600)

For further information and
locations, Phone (312) 921-5100.
A brochure is available.

Rx Product Index

<i>Antibiotics</i>	446
Beecham-Massengill Pharmaceuticals	
<i>Cordran</i>	454
Eli Lilly and Company	
<i>Dicarbosil</i>	510
Arch Laboratories, Inc.	
<i>Empirin w/Codeine</i>	2nd Cover
Burroughs Wellcome & Co.	
<i>Fleet Enema</i>	427
C. B. Fleet Co., Inc.	
<i>Hydergine</i>	452-453
Sandoz Pharmaceuticals	
<i>Kinesed</i>	450-451
Stuart Pharmaceuticals Division of I.C.I. America, Inc.	
<i>Librium</i>	444-445
Roche Laboratories	
<i>Mylanta II</i>	436
Stuart Pharmaceuticals Division of I.C.I. America, Inc.	
<i>Neosporin</i>	449
Burroughs Wellcome & Co.	
<i>Orinase</i>	500-501
The Upjohn Company	
<i>Preludin</i>	435
Geigy Pharmaceuticals	
<i>Premarin</i>	442-443
Ayerst Laboratories Div. American Home Products, Inc.	
<i>Synthroid</i>	438-439
Flint Laboratories Div. Travenol Laboratories, Inc.	
<i>Trobicin</i>	430-431
The Upjohn Company	
<i>Valium</i>	Back Cover
Roche Laboratories	
<i>Vasodilan</i>	3rd Cover
Mead Johnson & Co.	
<i>Versapen</i>	428
Bristol Laboratories	

Bicycle Spoke Injuries

(Continued from page 466)

dence of fractures in our series. The severity of avulsion injuries about the ankle and foot have been stressed by Izant et. al.² They list three mechanical reasons for the severity.

1. Laceration of the tissue from the knife like action of the spokes.
2. Crushing from the impingement between the wheel and frame of the bicycle.
3. Shearing injury from the coefficient of these two forces. Frequently avulsion injuries about the malleolus and ankle show up initially as severe bruising after 3 to 4 days. The tissue which has been crushed becomes devitalized due to thrombosed vessels. The resultant loss of tissue and ulceration may result in the need for skin grafting. In most cases the ulcerated area will heal in 5 to 6 weeks leaving a significant scar.

This was our experience in the six cases of avulsion injury to the ankle. No skin grafts were needed in this series.

A significant number of bicycle spoke injuries occurred with a single rider. This would indicate

the need for shielding of the spokes of the wheel for children's bicycles. Shielding, covering the upper half of the rear wheel is presently used on bicycles in the Netherlands, Denmark and England.¹ Because of the significant number of injuries to small children in carrier seats on bicycles, there is a need to improve their design. The foot rests and shielding of the feet on the presently designed carriers are not preventing bicycle spoke injuries.³ The banana seat found on the newer bicycles was an important cause of bicycle spoke injury. This type of seat makes it very easy for two riders to ride the bicycle. Since the second rider's legs are free, he is subject to the risk of foot and ankle injury due to bicycle spokes. More attention to the improvement of the type of footwear and pedals on bicycles is needed to prevent children's feet from slipping off pedals resulting in bicycle spoke injuries.

Physicians, and particularly pediatricians, have an important responsibility in communicating their experiences with bicycle accidents and their prevention to the children and their parents, civic, state and national authorities, bicycle manufacturers and their fellow physicians. ◀

References available from *IMJ* on request.

APPROVED

AVAILABLE NOW!

ISMS

MALPRACTICE INSURANCE

**Professional Liability Insurance
Program**

**Approved for Members
REGARDLESS of AGE
or SPECIALTY**

Protect Doctor's Integrity

Company will settle no claims without insured member's approval. Nuisance claims will be fought.

Improve Legal Climate

Company will retain outstanding defense counsels who are experts in professional-liability cases.

Provide Market Stability

Company will maintain an available market. Participation by the members is needed to assure this market.

Keep Members Informed

Company will tell members how to prevent claims . . . keep them aware of latest legal developments in malpractice field.

ISMS Supervision And Control

Premiums to reflect only the loss experience of ISMS. All questionable underwriting cases to be reviewed by ISMS. A UNIQUE FEATURE

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT ADMINISTRATORS:

PARKER VESCHURE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000



*"Sorry, Sire, but
'Dicarbosil' hasn't
been invented yet."*

Dicarbosil®
ANTACID



Write for Clinical Samples
ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

COOK COUNTY Graduate School of Medicine

CONTINUING EDUCATION COURSES STARTING DATES—1972

SPECIALTY REVIEW COURSE IN MEDICINE, May 22, June 5
SPECIALTY REVIEW COURSE IN RADIATION SCIENCE, May 22
SPECIALTY REVIEW COURSE IN SURGERY, Part I, August 7
SPECIALTY REVIEW COURSE IN ORTHOPAEDICS, September 11
SPECIALTY REVIEW COURSE IN NEUROLOGY, Clinical, Sept. 11
SPECIALTY REVIEW COURSE IN OB-GYN, October 16
ADVANCED PERIPHERAL VASCULAR SURGERY, One Week, July 17
MANAGEMENT OF COMPLICATIONS IN SURGERY, 4 Days, Sept. 12
SURGERY OF THE G.I. TRACT, One Week, September 25
FLUIDS & ELECTROLYTES, One Week, September 18
SURGERY OF THE HAND, Three Days, September 18
PEDIATRIC SURGERY, One Week, September 25
CLINICAL ENDOCRINOLOGY, One Week, September 25
BASIC INTERNAL MEDICINE, One Week, October 2
BASIC ELECTROCARDIOGRAPHY, One Week, October 9
NEUROMUSCULAR LEARNING DISORDERS IN CHILDREN, June 12
RHEUMATOLOGY REVIEW COURSE, One Week, June 26
PULMONARY FUNCTION TESTS, Three Days, July 12
CLINICAL ANESTHESIA PRACTICE, One Month, October 2

*Information concerning numerous other continuation
courses available upon request.*

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

Twenty Four Clinics for Crippled Children listed for June

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will count eighteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June—

- 1 Sterling—Sterling Community Hospital
- 1 Lake County Cardiac—Victory Memorial Hospital
- 1 Effingham—St. Anthony Memorial Hospital
- 6 Belleville—St. Elizabeth's Hospital
- 7 Hinsdale—Hinsdale Sanitarium
- 8 Springfield—St. John's Hospital
- 8 Rockford—St. Anthony Hospital
- 9 Chicago Heights Cardiac—St. James Hospital
- 13 Peoria—St. Francis Children's Hospital
- 13 E. St. Louis—Christian Welfare Hospital
- 14 Champaign-Urbana—McKinley Hospital
- 14 Springfield Pediatric Neurological—Diocesan Center
- 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 15 Bloomington—Mennonite Hospital
- 20 E. St. Louis—Christian Welfare Hospital
- 20 Rock Island Area General—Moline Public Hospital
- 21 Chicago Heights General—St. James Hospital
- 23 Chicago Heights Cardiac—St. James Hospital
- 23 Evanston—St. Francis Hospital
- 26 Peoria Cardiac—St. Francis Hospital
- 27 Peoria—St. Francis Hospital
- 27 Alton—Alton Memorial Hospital
- 27 Danville—Lake View Hospital
- 28 Aurora—St. Joseph Mercy Hospital

BLUE SHIELD REPORT



FOR *Illinois Physicians*

Summary of Annual Report, 1971

In last year's Blue Shield annual report, we spoke of maintaining our traditional leadership role in the health care field—not only through the payment of medical-surgical bills—but also by continued experimentation with evolving forms of health care delivery and financing. 1971 continued to be a year of expanded opportunities and challenges in these vital areas.

In addition, we made significant progress in the development of new benefits, intensified our contacts with physicians to assure quality care at the most economical cost possible and created new programs designed to increase our own efficiency. . . .

1971 Operating Results

Benefits of \$64,043,000 were provided for subscribers. 1,079,500 medical-surgical claims were paid during the year. Both are all-time highs. Total income reached \$70,256,000, up \$14,395,000 over 1970. Under Part B of Medicare—the medical-surgical portion of the law—\$51,138,000 was paid for 821,669 claims. . . .

. . . A particularly notable result of the past year's operations was the completion of a merger of the two Illinois Blue Shield Plans. In August of 1971, Medical-Surgical Service of Illinois—the Rockford Blue Shield Plan—merged with our Blue Shield Plan—offering the advantages of larger scale operations and additional stability to all Blue Shield members in Illinois.

Progress With Alternative Delivery and Finance Systems

. . . Substantial progress has been made by the Sangamon County Medical Society in the development of the Foundation for Medical Care for Central Illinois. This physicians' group wishes to proceed with an experimental program to provide service to approximately 3000 persons in 1972. Working jointly with Blue Shield and Blue Cross, agreement has been reached on a benefit program and significant progress has been made in developing the procedures for physician review of claims and related matters.

Blue Shield and Blue Cross are also currently discussing foundation programs with other medical societies throughout the state. Early progress in these discussions is encouraging and we are confident that a number of these programs will develop successfully within the near future.

At the same time, Blue Shield and Blue Cross are actively working with several group practice clinics in developing prepaid group practice programs. A program was established with the Carbondale Mod-

el Cities Agency and the Carbondale Clinic in early 1971, and is now in its second year of operation. . . .

In the Chicago area, a prepaid group practice arrangement will begin operation during the spring of 1972. This experimental program—organized with the Ravenswood Medical Group at the Ravenswood Hospital Medical Center—is expected to be the first in a network of group practice programs in which benefits of physician groups are provided in cooperation with Blue Shield and Blue Cross. . . .

Other Activities and Milestones

While that twin issues of alternative delivery and financing and cost containment provided the focus of our attention during 1971, Blue Shield—often in cooperation with Blue Cross—was deeply involved in many other health care projects. Among them were:

—The development of PreDent—a prepaid dental program underwritten by Blue Shield's and Blue Cross' affiliate, Fort Dearborn Life Insurance Company—was completed and is ready for marketing within the immediate future.

—Our new Mobile Information Center traveled throughout the state, distributing Blue Shield, Blue Cross and public health information and answering questions about the corporations. The office-on-wheels traveled 20,000 miles and has been visited by over 25,000 individuals since it became operational in September.

—Our Affirmative Action Committee continued its efforts to provide employment and promotion opportunities for minority group members. One-third of our employees are members of minority groups. As part of the Affirmative Action program, the committee is currently inquiring into the hiring practices of Blue Shield suppliers.

—A Volunteer Service Bureau was started by Blue Shield employees so that they would have an opportunity to offer their services to public service organizations of their choice.

. . . Blue Shield made important progress in 1971 by placing itself squarely in the mainstream of thought regarding adequate health care delivery. We intend to remain innovative and contemporary in our approaches to the many problems facing health care in America. But much remains to be done before we reach our goal—a health care system that benefits and protects everyone.

We invite your interest, comments and support to help us realize this objective.

Robert M. Redinger
President

ASK BLUE SHIELD

• • • ABOUT MEDICARE

PART B MEDICARE COVERAGE STATUS OF SOME SPECIAL SERVICES

The Social Security Administration periodically reports on the coverage status under Part B Medicare of special procedures, services, or items of equipment. Some of these are shown below.

Ultrasonic Surgery—Payment may be made for ultrasonic surgery, a procedure utilizing a machine which produces ultrasonic waves of high intensity and frequency that selectively irradiate certain portions of the inner ear, thereby destroying the tissues, when required in the treatment of patients with severe and recurrent episodes of vertigo due to Meniere's syndrome.

Cytotoxic Food Tests—These in vitro laboratory tests performed on a venous blood sample to indicate whether the patient has circulation antibodies against a specific food extract tested are useful as an adjunct to in vivo clinical allergy tests in complex allergy problems, and, therefore, are covered by the Part B program.

His Bundle Study—Coverage of this specialized electrocardiography requiring catheterization of the right side of the heart is limited. Payment may be made when this service is provided to patients with complex ongoing arrhythmias, those with intermittent or permanent heart block in whom pacemaker implantation is being considered, and those who have recently developed heart block secondary to myocardial infarction. When heart catheterization and the His Bundle Study are performed at the same time, the program will provide benefits for only one catheterization and a small additional allowance for the study.

REQUESTING A MEDICAL REVIEW

Illinois Medical Service as Part B Medicare carrier for Cook County reminds physicians that all requests by physicians or their Medicare patients for a review of a Part B Medicare claim must be in writing, according to Social Security Administration regulations. The written request may be made either by a letter to the Part B Medicare carrier or by completing form SSA 1964 which may be obtained from the Medicare office or from any Social Security Administration office. However, the written request must be made **WITHIN SIX MONTHS OF THE DATE ON THE EXPLANATION OF MEDICARE BENEFITS (EOMB) OR REMITTANCE NOTICE.**

When requesting a review, please be sure that the patient's name and Medicare number and the date(s) of service are indicated. Include any additional information (e.g., operating report, description of the patient's condition, unusual procedures or circumstances involved) which you feel would be an aid in reviewing the claim. Also, please include the case number and date which appear in the upper right corner of the Explanation of Medicare Benefits or the numbers which appear under the patient's Medicare number in column 2 of the Remittance Notice as these will help us return the review results to you promptly.

SSA Changes In Lab Certification

The following laboratories have been certified for Medicare participation by the Social Security Administration:

International Clinical Laboratory
2165 North Milwaukee Avenue
Chicago, Illinois 60647

2011 Medical Laboratory
2011 East 75th Street
Chicago, Illinois 60649

Chicago Medical Laboratory, Inc.
1518 North Ashland Avenue
Chicago, Illinois 60622

Records for the following laboratory have been amended to show that it is located in Cook County:

Fox Valley Medical Laboratory
860 Summit Street
Elgin, Illinois 60120

The Social Security Administration no longer considers the following laboratories to be certified for Medicare participation:

Ashland Clinical Laboratory
2753 West North Avenue
Chicago, Illinois 60647

Park Grove Medical Laboratory
8048 South Cottage Grove
Chicago, Illinois

26th Street Medical Center Laboratory
3814 West 26th Street
Chicago, Illinois 60623

Hyde Park Medical Laboratory
5240 South Harper Avenue
Chicago, Illinois 60615



illinois medical journal

volume 141, number 6

June, 1972

staff	editor	Theodore R. Van Dellen, M.D.
	managing editor	Richard A. Ott
	assistant editor	Gerald A. Frankel
	advertising manager	John A. Kinney
	executive administrator	Roger N. White

cumulative index—Volume 141	582
-----------------------------------	-----

clinical articles	Hypothyroidism <i>Frederick G. Berlinger, M.D.</i>	537
	Allergic parotitis from foods <i>Joseph Interlandi, M.D.</i>	541
	Sexual pressures in the society <i>Mary S. Calderone, M.D.</i>	544
	Autotransplantation of Splenic Tissue—"Splenosis" <i>V. D. Jayaraman, M.D., B. H. Neiman, M.D.</i>	556
	<i>R. D. Schreiber, M.D.</i>	556
	Maternal death study case report No. 4 <i>Robert E. Hartman</i>	559

trauma center	Fluid therapy in hemorrhagic shock <i>D. C. Siegel, M.D., Gerald S. Moss, M.D.</i>	548
	<i>Alan Cochlin, M.S.</i>	548

surgical grand rounds	Submaxillary gland cylindroma	551
--------------------------	-------------------------------------	-----

features	the presidents page	528
	the viewbox	542
	ekg of the month	547
	doctors library	577
	new pharmaceutical specialties	565
	editorials	563
	practice management	561
	obituaries	574
	pulse of the doctor's wife	575
	what goes on	567
	clinics for the handicapped children	568
	membership forum	570
news	589	

(cover by Mike White & Associates illustrates the article Sexual Pressures in the Society which begins on page 544.)

Microfilm copies of current as well as some back issues of the Illinois Medical Journal may be purchased from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106.



Published monthly by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill., 60601. Copyright, 1972, The Illinois State Medical Society.

Subscription \$5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$7.50 per year for all foreign countries included in the Universal Postal Union. Canada \$5.50 U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the Illinois Medical Journal. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

REGISTERED
AIA
MEDIA DATA FORM

He won't resist feeling better with **Mylanta[®]**

Because the taste is good.

- ☐ promptly relieves hyperacidity
- ☐ also relieves fullness and bloating
- ☐ non-constipating



LIQUID **MYLANTA[®]** TABLETS

aluminum and magnesium hydroxides with simethicone



STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109

Physicians don't need a regular check up.

When a physician comes to us to borrow money, he gets the kind of treatment he deserves. We don't think it's necessary to ask a lot of involved or embarrassing questions.

Even if you want to borrow important money, like \$15,000 for new equipment. Or enough to buy that sail boat you've always wanted.

We promise you preferred rates with no red tape or hassle. Tell us what kind

of deal you want, and we'll try to work it out for you.

For some uncomplicated financial help call Jim Shea at (312) 661-5841. Jim's one of the people who make the difference at American National.

And he's ready to give you our special treatment.



**The Idea Bank
American National Bank
and Trust Company of Chicago**

LaSalle at Washington 60690
Phone (312) 661-5000 Member FDIC

the presidents page



THE CHOICE IS YOURS!

“IT IS THE DUTY of ALL physicians to keep legislators informed of the REAL health care issues that face Americans today!”

So said U.S. Congressman Tim Lee Carter, (R-Kentucky) to Illinois physicians during our 1972 Washington Roundup. And Congressman Carter, as both a legislator AND a physician, knows what he's talking about.

Unfortunately not enough Illinois physicians are practicing what Dr. Carter is preaching. While 1972 is an election year . . . a year in which our medical future may be shaped . . . only about 50% of our members are supporting the Illinois Medical Political Action Committee (IMPAC).

A primary purpose of IMPAC is to insure support for political candidates who are knowledgeable about what Dr. Carter calls “the REAL health care issues.”

Most legislators ARE willing to listen . . . and part of our job is to tell these legislators OUR side of the health care story . . . to make sure they know both sides of important health care issues.

During this session of the Illinois General Assembly, there was success in insuring that licensure of physicians will continue to be a state—not a local government—function. Local licen-

sure was proposed for only one reason—increased revenue for local government!

And we physicians would have provided the revenue! These costs would eventually have been passed on to patients with one inevitable result: More criticism of physicians for contributing to soaring health care costs.

The local licensure provision was defeated because dedicated people, including physicians, were willing to take time out from their busy practices to actively work against the proposal.

Thanks to them, YOU won't be subjected to local licensing fees!

Are you doing anything in return? Are YOU doing your part?

Even paying annual IMPAC dues of \$25 will help. I don't think \$25 a year is too much to invest in your medical future. Does that future hold more—or less—government intervention?

The choice is YOURS!

Frank J. Jirka, M.D.



BY FREDERICK G. BERLINGER, M.D./CHICAGO

Hypothyroidism

A state of diminished thyroid hormone output from the thyroid gland, Hypothyroidism, is seen at all ages. (In this paper the terms "hypothyroidism" and "myxedema" will be used interchangeably.)

On the basis of age categories, it is seen as cretinism, juvenile myxedema, and adult myxedema.

Cretinism is defined as thyroid failure in the newborn. It may be caused by iodine deficiency in the few endemic areas left in the world where supplemental iodine is not added to the dietary salt, and other food stuffs, but this is not a problem in the United States. The most common type of cretinism in this country today is the idiopathic athyreotic form. A less common etiology is goitrous cretinism, in which various inborn errors of metabolism cause congenital defects in hormone synthesis, or release secondary to deficient thyroidal enzymes. A second cause of goiter in the newborn that may be associated with hypothyroidism is the overzealous use of antithyroid drugs used in the treatment of pregnant females with thyrotoxicosis.

Regardless of its etiology, the early recognition of hypothyroidism in the infant is of paramount importance, as early treatment may prevent permanent brain damage. The diagnosis, if kept in mind, is not difficult and should be considered in any infant who exhibits failure to thrive.

The signs and symptoms of cretinism include most of the same findings as in adult myxedema, which will be described later in this paper, plus

marked retardation in all parameters of growth and development. The typical cretin may be described as a "good baby." They demonstrate little physical activity and cry less frequently than normal babies. Their cry is usually low pitched and croaking. Dry, coarse skin, constipation, large protruding tongue, poor appetite, abdominal distention often with marked umbilical hernias, slow pulse, decreased stature, and respiratory difficulties are prominent findings.

Hypothyroidism

Skeletal maturation is markedly retarded. Wrist X-rays usually reveal complete absence of carpal ossification centers. In later life, retarded bone age and epiphyseal dysgenesis are common Roentgen findings. Retardation in the development and growth of teeth, hair, and nails becomes evident in infancy and early childhood. Central nervous system changes include obvious mental retardation as the child grows older, plus occasional deafness and seizure disorders. The round, dull, frog-like face with large protruding tongue is a classical finding in cretinism.

The diagnosis of cretinism is made on the basis of the clinical picture plus the laboratory findings of low levels of circulating thyroid hormones.

Juvenile myxedema may be defined as the spontaneous occurrence of hypothyroidism in a previously normal child prior to puberty and the attainment of full growth and development. While less serious than cretinism, juvenile myxedema if untreated will cause retarded growth and development. The extent of the retardation depends upon the degree of hypothyroidism and the age of onset.

The etiology of juvenile myxedema may be the same as for adult myxedema, or it may be due to an acquired defect in any of several different enzymatically controlled steps in thyroid hormone synthesis. The latter case is usually associated with a goiter, but is quite uncommon. Athyreosis in this age group may represent the end stage of some autoimmune or inflammatory mechanism (e.g. Hashimoto's or acute thyroiditis), or the failure of a small thyroid remnant. The surgical removal of functioning aberrant thyroid tissue (e.g. a sublingual thyroid) may be another cause of juvenile myxedema if this aberrant thyroid is the only functioning thyroid tissue in the body. The other more common etiologic entities are described under adult myxedema.

The age of onset varies. The more severe growth disturbances will usually occur in patients whose symptoms began at an earlier age.

The signs and symptoms of juvenile myxedema are the same as in adult myxedema, but one important sign which is not seen in the adult may be the presence of hirsutism of the back.

Adult myxedema (Gull's disease), as well as juvenile myxedema, may be due to thyroid failure (primary myxedema), or may be sec-

ondary to deficient TSH production by the pituitary gland (secondary myxedema). All cases of myxedema should have a TSH stimulation test to determine if primary thyroid failure or hypopituitarism is the cause of the hypothyroidism. Whenever possible, the TSH test should be done before the patient is placed on thyroid replacement therapy.

The etiology for primary thyroid failure in the adult includes iatrogenic causes such as the surgical or radio-iodine treatments for hyperthyroidism.¹ Overzealous use of antithyroid drugs in the treatment of thyrotoxicosis may also cause certain degrees of hypothyroidism.²

Chronic thyroiditis, especially the Hashimoto variety, is becoming a more common etiologic factor. It is now thought that Hashimoto's thyroiditis represents one of the autoimmune disorders. Many cases of previously described spontaneous (idiopathic) thyroid atrophy have been found to have circulating anti-thyroid antibodies.³ Thus, a number of the previously diagnosed cases of idiopathic myxedema may also be due to this same autoimmune mechanism. Hypothyroidism occurring in adults with demonstrable goiters is most likely due to Hashimoto's thyroiditis.

It is doubtful in this country that dietary iodine deficiency can still be implicated in the etiology of hypothyroidism. Other rare causes of thyroid gland destruction resulting in myxedema include acute suppurative thyroiditis, metastatic cancer, tuberculosis and other granulomas, etc. Acquired enzymatic deficiencies causing inhibition of thyroid hormone synthesis and release do occur spontaneously in adults; however, this is quite rare.

As in all diseases of the thyroid gland, myxedema occurs in a much higher incidence in women. Upward of 80% of cases of spontaneous myxedema occur in females.⁴

The age of onset varies widely. However the majority of cases of primary myxedema occur in the third to sixth decades.

Signs and symptoms of overt hypothyroidism

FREDERICK G. BERLINGER, M.D., is the director of the Dept. of Endocrinology and Metabolism, Cook County Hospital, and assistant professor of medicine at the Abrohom Lincoln School of Medicine University of Illinois. He took his internship at Montefiore Hospital and his residency at Bellevue Hospital.



can involve all organ systems. Broadly speaking, the main clinical findings are caused by two general pathological processes: 1) hypometabolism per se, and 2) mucoprotein infiltration (myxedema fluid) of various tissues. The former probably accounts for the classical findings of bradycardia, lethargy, slow mentation, cold intolerance, menstrual and bowel irregularities, etc. The classical skin and mucous membrane changes as well as serous effusions along serosal surfaces and organomegaly are due primarily to infiltration by the mucoprotein.

Classical physical findings include the following: the skin is dry, thick, coarse, scaly, cool and puffy, but non-pitting. Skin color is usually pale but may be waxy-yellow if hypercarotenemia is present. The face is puffy with blepharoptosis and eyelid edema. Coarse facial features with a dull expression are common. The blepharoptosis may be so severe that the patient needs to elevate the eyebrows in order to see. With myxedematous infiltration of the vocal cords, the voice becomes low-pitched or croaking. Infiltration of the oral mucous membranes and tongue causes macroglossia and subsequent difficulties with phonation. Loss of scalp and body hair, including the eyebrows, is common. Both the hair and nails become coarse and brittle, and break off easily.

The most consistent finding in the cardiovascular system is the presence of bradycardia. The cardiac output is reduced. Blood volume is often decreased secondary to a normocytic-normochronic anemia. Iron deficiency anemia may be seen with blood loss, often due to menorrhagia. Occasionally, megaloblastic anemia is seen in patients with both pernicious anemia and myxedema. Many of these latter patients demonstrate autoantibodies against the thyroid gland and the gastric mucosa. Therapy requires Vitamin B-12 as well as thyroid replacement. Cardiomegaly may be due to concomitant heart disease, pericardial effusion, or so-called primary myxedema heart disease. The EKG usually shows only a sinus bradycardia. A prolonged P-R interval may be associated with the slow rate. Congestive heart failure is not common in uncomplicated hypothyroidism. However, both congestive heart failure and angina pectoris may be precipitated by too rapid thyroid replacement therapy, especially in elderly patients with underlying coronary atherosclerosis.

Examination of the gastrointestinal tract often reveals macroglossia. Atrophic gastric and colonic mucosa may be secondary to diffuse infiltration of the G-I tract with myxedema fluid. The

former is often associated with gastric achlorhydria and macrocytic anemia. These morphologic changes and the hypometabolic state account for the common findings of decreased peristaltic activity with resultant constipation, slow absorption of carbohydrate causing flattening of the glucose tolerance test, and decreased absorption of Vitamin A with resultant hypercarotenemia. Other gastrointestinal tract symptoms include anorexia with paradoxical mild weight gain (usually due to fluid retention), constipation, abdominal distention often secondary to intestinal dilatation and/or ascites, nonspecific dull abdominal pain, and occasionally, umbilical hernia.⁵ Rarely, marked ascites associated with hepatosplenomegaly may lead to the erroneous diagnosis of cirrhosis of the liver.

The effect of hypothyroidism on protein metabolism is most clearly seen in children in whom myxedema is one of the more common causes of under stature and delayed development. In cretins, epiphyseal dysgenesis may be a pathognomonic sign. Occasionally elevated serum proteins and uric acid levels are found.

High blood lipids and cholesterol are the main findings in the altered metabolism of fat seen with myxedema.

Renal function studies are usually normal, though there may be a moderate proteinuria.

As mentioned previously, the skeletal system shows retarded maturation.

Neuromuscular involvement is best demonstrated by the delayed relaxation phase of the deep tendon reflexes. In general, neuromuscular irritability is depressed.

Central nervous system involvement is best exemplified by personality changes. Anything from mild mental sluggishness to full-blown "myxedema madness" may be manifested. Overt psychoses are not uncommon in patients with chronic hypothyroidism. Myxedema coma is a very rare, but often fatal outcome of long-standing untreated hypothyroidism.

Involvement of the female reproductive tract is most often associated with any type of menstrual irregularity. Sterility is not uncommon in long-standing untreated myxedema. Menorrhagia may be the cause of an iron deficiency anemia.

The effects of hypothyroidism on other endocrine organs may easily be overlooked. If the hypothyroidism is secondary to panhypopituitarism evidence of adrenal and gonadal insufficiency should be looked for. Unitropic deficiency of TSH is extremely rare. Thus, nearly all cases of secondary hypothyroidism are caused by pan-

Hypothyroidism

hypopituitarism. Relative adrenal insufficiency also may be seen in cases of long-standing primary myxedema. In these cases, infiltration of the adrenal glands with myxedema fluid is thought to cause decreased steroid output. It is important to bear in mind that a patient with hypothyroidism might not show evidence of adrenal insufficiency while in the hypometabolic state. In these patients rapid thyroid replacement may precipitate an Addisonian crisis. Thus, all patients with hypopituitarism must have their steroids replaced prior to thyroid therapy, and patients with chronic severe primary myxedema should be prophylactically covered with steroid therapy as their thyroid replacement is built up to euthyroid levels. Obviously, all patients with hypothyroidism must be tested for hypopituitarism prior to the institution of thyroid replacement. This is most easily accomplished with a TSH stimulation test. With severe myxedema, one may want to cover the patient with steroids during the TSH stimulation test.

In summary, the most common symptoms of hypothyroidism include weakness, dry, coarse skin, lethargy, slow speech, eyelid edema, cold sensation, cold skin, thick tongue, and facial edema. Other common symptoms include coarse hair, skin pallor, memory impairment, constipation, weight gain, alopecia, peripheral edema, hoarse voice, dyspnea, and anorexia. Less common manifestations include nervousness, menorrhagia, palpitations, deafness, and precordial pain.⁶

Noteworthy signs include blepharoptosis, delayed relaxation of the deep tendon reflex, personality changes, paresthesias, serous effusions, and, rarely, intestinal obstruction.

Laboratory data used in the diagnosis of hypothyroidism include low values found in the PBI, BEI, T-3, T-4, and radioactive iodine uptake. The thyroid scan should show decreased uptake throughout the entire gland. With hypopituitarism, administration of TSH should increase the radioactive iodine uptake. Less reliable tests include a decreased BMR, hypercholesterolemia, hyperlipemia, and hypercarotenemia.

The goal of therapy is aimed at reestablishing the eumetabolic state. In general, the selection of the pharmacological preparation makes relatively little difference. Dessicated thyroid as well as sodium Levo-Thyroxine will elevate, while Triiodothyronine will depress the PBI levels. The newer combinations of synthetic Thyroxine and Triiodothyronine have the advantage of normalizing the PBI levels when euthyroid replacement levels are reached.

The most important aspect of thyroid replacement therapy is to start the patient on very low levels and build up the dose very slowly over several weeks to months. This is especially important in the elderly patient who may have underlying arteriosclerotic cardiovascular disease and in whom rapid progression to full replacement dosage may precipitate angina or thromboembolic phenomena. In these patients it may be advisable to keep the metabolic level in the low normal or slightly hypothyroid range in order to avoid complications.

All patients with hypopituitarism and many patients with severe chronic primary myxedema should be given concomitant steroid replacement. The former will, of course, require life-long steroids at full replacement levels (as well as sex hormones, depending upon the patient's age). The latter require steroid coverage only while their thyroid replacement is built up to euthyroid levels. Once they become eumetabolic, the steroids may then be gradually tapered off.

References

1. Bronsky, D., Kiamko, R. T., Waldstein, S. S.: "Post-therapeutic Myxedema," *Arch. Intern. Med.*, 121:113-117, Feb., 1968.
2. Means, J. H., DeGroot, L. J., Stanbury, J. B.: *THE THYROID AND ITS DISEASES*, 3rd edition, 1963; McGraw-Hill, p. 290. New York.
3. Bronsky, D., Meltzer, J. L., Waldstein, S. S.: "Idiopathic Myxedema and Myasthenia Gravis," *Amer. J. Med.*, 43:965-972, Dec., 1967.
4. Werner, S. C., *THE THYROID*, second edition, 1962, New York City, Harper and Row, p. 729.
5. Haley, H. B., Leigh, C., Bronsky, D., Waldstein, S. S., "Ascites and Intestinal Obstruction in Myxedema," *Arch. Surg.*, 85:328-333, Aug., 1962.
6. Williams, R. H., *TEXTBOOK OF ENDOCRINOLOGY*, 4th Edition, Philadelphia, W. B. Saunders, 1969, p. 240.

U.S. cancer deaths by sex

More men than women died of cancer last year. This has been true since 1949. The ratio in 1972 will be about 55 men to 45 women.

Controlling Allergic Parotitis From Foods

Recurrent swelling of the parotid gland is most often due to infection and/or salivary calculi. Occasional reports discuss the other causes of recurrent parotid swelling, some of which are truly a parotitis. Of course, mumps is the most common cause of parotitis, permanent immunity is the rule, although there are instances of a re-infection by the mumps virus. Postvaccination "mumps" may mean failure of the newly available vaccine, but a recent report by Zollar and Mufson suggests that this may be, in fact, an infection with another virus, the parainfluenza Virus 3. It is necessary to document such etiologies as well as consideration of the non-infectious causes of parotid swelling.

Besides infection and calculi, other possible causes of parotid swelling include dehydration, dental trauma, auto-immune Sjogén's Syndrome, hereditary or congenital abnormalities of the ducts, recurrent sialorrhea of unknown etiology, so-called nutritional mumps seen in poor communities especially in association with pellagra, and allergy and drug hypersensitivity.

Drug hypersensitivity reactions are rare, but have been recognized with the use of phenylbutazone, oxyphenbutazone, isoprenaline, iodine, thiouracil, thiocyanate and phenothiazine. Food allergy has often been suggested as a possible cause, but there are relatively few reports of cases specifically diagnosed. In the last twenty years Pearson in England has published several papers, and so have Waldbott and Shea in the United States, and Cohen of England. Allergy was considered as the etiological factor on the basis of failure to demonstrate other more common causes, as well as with a concomitant history of "conventional" allergic symptoms such as asthma or urticaria, or with the sometimes favorable response to anti-histamines. Specific offending antigens in foods rarely have been demonstrated, and successful control not often seen.

While this report involves only a single case, dramatic as it may be, the primary purpose in presenting it is to point up the value of the methods used in the diagnosis and management of any perplexing problem suspected of being of allergic origin. The prolonged fast, Bryan's Cytotoxic Food Test, and Lee's Provocative Food Test and neutralizing food injections are indispensable tools with great clinical worth. With their aid, many of the bizarre and long-suspected food allergy symptoms should now be more often resolved.

CASE REPORT

The patient, a 21-year-old female, had had almost constant swelling of the parotids of vary-
(Continued on page 579)

JOSEPH INTERLANDI, M.D., F.A.C.A., limits his practice to allergy and lectures in allergy at the Loyola Dental School. He served his internship at Cook County Hospital and is a fellow of the American College of Allergists and the American Association of Clinical Immunologists and Allergists. He is also a member of the American Academy of Allergy and the New York Academy of Science.





the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



Fig. 1

This is a 54-year-old male who had bouts of constipation over the past three to four years. In the week prior to admission he had complained of fairly acute abdominal pain which was accompanied by fever. Physical examination revealed tenderness over the abdomen which appeared to be somewhat more localized in the lower quadrants. A scout film of the abdomen was noncontributory. A barium enema was done, Figure 1.

What's your diagnosis?

1. Carcinoma of the sigmoid
2. Diverticulitis
3. Ulcerative colitis with perforation
4. Granulomatous colitis

(Answer on page 579)

Autopsy Ruling Threatens Progressive Medicine

“Go ahead and sue the doctor.”

That casual bit of advice, whether given by a friend or legal counsel, glitters with the allure of easy money. Now a recent court ruling on autopsy offers the “go ahead and sue” advocates a golden opportunity. And physicians who do not follow the guidelines of the new ruling may find themselves with malpractice suits, higher insurance premiums, and even a tarnished professional reputation.

The ruling by Cook County Circuit Court Judge Joseph M. Wosik could affect hospital teaching practices.

The ruling states: “The right to bury the body of a relative without mutilation by autopsy is a quasi-property right [for] surviving relatives and unless there is consent and authorization [by them] . . . there is a deprivation of this right in those not consenting.”

Court Upholds Plaintiff

In the case of *Leno V. St. Joseph Hospital* the Circuit Court of Cook County held that all relatives in the same class have property rights in the remains of a deceased person and that each of them should give consent to an autopsy. In this case the closest available relatives to the deceased were two brothers, one of whom did not give his consent, and the Court awarded him damages in the sum of \$1,000 but the other brother who had consented was denied recovery. Although this decision by a trial court is not controlling any other case, it might lead to similar claims.

Attorneys for the American Hospital Association, the American Medical Association, the College of American Pathologists, the Illinois Hospital Association and the Illinois State Medical Society have met on several occasions since this decision and are in substantial agreement on the course of action to be taken by physicians.

The Illinois statute on autopsies permits authorization of an autopsy by any one member of a class of surviving relatives unless any other relative with an equal right to make the decision objects in writing or by telephone or telegraph. In the *Leno* case, the court held the statute to be unconstitutional to the extent that it gives one member of a class of relatives authority to abrogate the rights of other members of the class.

It is unknown whether this ruling will be applied in other cases involving other autopsies. Until the questions raised by this decision have been resolved, greater care is required in obtaining consents to autopsies, in order to avoid legal risk. For maximum

protection against legal risks, autopsies should be performed only if consent is obtained from all members of the class of relatives who have the right to make the authorization.

Obtaining Authorization

If proper authorization for an autopsy is obtained from the spouse of the deceased patient, this is sufficient.

Next, where there is no surviving spouse but one adult child, or no surviving spouse, children or parents, but one brother or sister, the consent of the one relative is also sufficient. Where members of the same class of surviving relatives are more than one in number, such as several brothers and sisters, a consent should be obtained from all of them.

If there is no surviving spouse and if there are no children or brothers or sisters of the deceased, consent by both parents of the deceased or by the surviving parent is sufficient.

If there is no surviving spouse, but the deceased has had children who either are alive or have died without themselves having children, the consent of all living adult children of the deceased is probably sufficient.

For maximum legal protection in other situations, it is probably impractical to attempt to obtain all of the necessary authorizations.

It is recognized that the performance of autopsies is necessary for maintaining adequate levels of post-graduate medical education in teaching hospitals under internship and residency programs approved by the Council on Medical Education of the American Medical Association. It is also recognized that the performance of autopsies is necessary for the maintenance of high standards of patient care under the standards of the Joint Commission on Accreditation of Hospitals. These necessities may justify the acceptance by hospitals and physicians of some calculated legal risks.

Where it is virtually impossible to obtain the authorization for an autopsy from all persons who may have a right to decide, either because of the number of persons involved or because of the inaccessibility of some of them, hospitals and physicians may sometimes be willing to accept the calculated legal risk. This risk cannot be eliminated entirely, but it may be minimized to some extent by obtaining the written authorization by one or more adult children of the deceased patient, or if there are no adult children the written consent of one or more adult brothers or sisters. Two such written consents would be preferable. ◀

SEXUAL PRESSURES IN THE SOCIETY



IN discussing any topic as potentially explosive and divisive as human sexuality and sexual behavior, it is vital to apply the criteria usual for any scientific discussion of human phenomena. These criteria include observation, data gathering, research, analysis—but on human sexuality at this stage of the game not necessarily conclusions. It is especially important to avoid giving opinions as if they were facts, and at all costs conclusions based on insufficient, incomplete or out of context data should be avoided like the plague. This requires the scientist to put aside his own biases about human sexual behavior and to examine with utmost objectivity such facts as can reasonably be established—a difficult task in this particular field, clouded as it is with emotionalism.

At this stage in the evolution of our understanding of human sexuality, I would divide sexual pressures into two groups:

1. Erotic (genital) drive—endogenous.
2. Societal (status) sexual pressures—exogenous.
 - a. prosexual
 - b. anti- or counter-sexual

It should be recognized that sexual pressures whether endogenous or exogenous bear on married and unmarried alike, and in all age groups. But both endogenous and exogenous sexual pressures impinge most forcefully on the age group 15-30 years, the group in which erotic (endogenous) drives are at their height or rapidly reaching there, and in which the social (exogenous) pressures relating to sexual behavior in dating, marriage and child bearing are most heavily brought to bear.

Actually, the endogenous and exogenous pressures are apt to run counter to each other, for the endogenous drive to express or experience eroticism is inevitable and strong as is characteristic for the 15-30 age group, while at the same

time the society tries to impose a fairly rigid social framework outside of which expression of erotic drive is not acceptable. This rigid framework for dating, marriage and parenthood behavior can create such obvious paradoxes as tacit approval of premarital sex activity for males but not for females. There are also the more subtle paradoxes that place a premium on virginity of females by drawing the line at intercourse, but shrugging the shoulders and ignoring all forms of sex play *short* of intercourse. This same rigid social framework leads to such anti and counter sexual pressures as denial of the valid sexuality of the young, of the single, of the handicapped in any form and of the aging. In the handicapped and aging, particularly over 60, this attitude results in a reaction to the castrating attitudes by the society. The young see through such hypocrisies and fakes and reject them.

So the young person 15-30 finds himself increasingly in the past ten years at the point of pressure of conflict, and this has created a pain-

ful situation for all concerned. What are some of the factors involved in this situation?

One prime factor is the marked change in the status of women, with its increasing acceptance—indeed expectation—by women that they should achieve and enjoy sexual responsiveness. This was true even before the epoch-making studies of Masters and Johnson, and has placed women in a paradoxical position in which they are still expected to accept the double standard while being subverted from it by males as well as by their own needs—an untenable position.

Another prime reason for the changes in sexual behavior in the past decade, whether real or apparent, is the growing openness of an increasingly diverse and pluralistic society. The openness is most striking in terms of public behavior (eating or grooming or petting in public) or at the level of the communications media, with almost instantaneous communication to every individual of whatever is happening. We should also consider the social context in which changes in sexual behavior have taken place:

First, the disturbed social scene—disturbed in terms of war, interracial and intersocial strife, as well as in terms of high level aspirations for status and possessions giving the impression of an affluence that is actually belied by the inflationary spiral.

Second, the increased freedom accorded to young people at ever decreasing ages by the adult population. There is some feeling that it is the young people who demand this freedom, but in fact it is the older generation that, by decreasing controls, has forced it on the young.

Third is the accompanying increased laxity of behavior of the middle generations themselves as clearly observed by the young: the divorce rate has risen to almost one in three marriages, and the new phenomena of sexual freedom, swinging, consumption of pornography, etc. are characteristics not so much of the college age but of the younger middle-aged.

Fourth, the freedom of sexual expression in all the media strikingly increased in recent years.

The effects of these factors are observable in changes of attitudes and behavior as observed by various social scientists. Bell and Chaskes¹ and Christensen & Gregg² have demonstrated that changes in sexual *behavior* of college women between 1958 and 1968 have been in the direction of greatly increased percentages (more than double) having premarital sexual relations, although the increase is greater in the early stages of dating and going steady than during engagement, when it already was high. A correspond-

ing change in *attitudes* showed that far fewer in 1968 felt they had gone "too far" than in 1958, whether intercourse took place during dating, going steady or the engagement.

It is important to remember the admonitions of the social scientists—that these changes and many others observed in the college generation appear to be more caused than causing; they not only reflect changes in the sexual mores of the middle adult generation, but also reflects (and this is attested to by many observers including college chaplains) the search of the young for relationships that they state will have more meaning in their lives than the relationships (including marriage) that they have observed among their parents.

As far as the medical scientist is concerned, in dealing with all of these questions it seems to us in SIECUS that he has a real obligation to inform himself of what *is* in order not to fall into the trap of joining that great company of the deliberately or unintentionally uninformed who proclaim what *should* be.

We can observe these latter generalizing that the suicide rate in Sweden is due to the Swedish school sex education program, ignoring the facts that Swedish programs have consisted primarily of *reproductive* rather than education about human sexual relationships and have not been universally applied in Swedish schools; and that Sweden's suicide rate is far lower than that in the state of California, for instance, where there have been no sex education programs at all except in a few specific towns. But the fact that Scandinavian countries have considerably lower venereal disease and divorce rates than does the United States is conveniently ignored by these same self-styled authorities as is the undoubted fact that the sex crime rate in Denmark has dropped markedly since the change in law that permits adults to have free access to sexually explicit materials while yet protecting young people under 18 from them.

MARY S. CALDERONE, M.D., M.P.H. is the Director and co-founder of the Sex Information and Education Council of the U.S. (SIECUS) New York City. She received her M.D. from the University of Rochester Medical School, N.Y. and M.P.H. from Columbia University School of Public Health, New York. From 1953 to 1964 she held the position of Medical Director, Planned Parenthood Federation of America, New York, N.Y.



Sexual Pressures in Society

Sales of sexually explicit materials to the Danes also have fallen off, but remain high to U.S. and West German tourists.

The biggest factor all of us must confront is the plain fact of endogenous sex drive in the not married of any age group over 14, and what to do about it. The focal point of societal anxiety is the young age group; the age group over 50 is totally ignored by the society as to its sexual needs, yet many single women and men between 50 and 80 suffer acutely not only from loneliness for companionship but from sexual deprivation. Many widowed or divorced people in their 60's and 70's come up to me after lectures and tell me so.

So the facts are plain, and so is the basic question related to the fact that the sex drive is the norm to being human at any age. We find ourselves at a moment in history when sex not only can but must be separated from procreation. Concurrently the churches have openly recognized the vital, communicative role of sex apart from its reproductive role—but this is only half the story. To young and old society offers only a babel of confused, conflicting rationales for sex behavior running the gamut from total expression to total repression. Science is, for the most part, too silent on this subject, outside of some fact gathering and a great deal of emotional opinion giving. Physicians and other scientists should bear in mind that from them must come scientifically valid and validated answers to one basic question:

How, when, and to what degree (if any) are erotic expressions of the sex drive (and which of the many possible ones of these) to be regarded and treated as acceptable, desirable or integral to the psychosexual development of the maturing individual and to the psychosocial health of the adult of any age?

Physicians must accept the challenge in their communities of identifying and joining with other leaders in education, religion, behavioral sciences and parental groups in developing community support for programs that give access by our children and young people to such facts as we presently have about human sexuality and sexual behavior. Nash and Loudon³ reported in the *JAMA* a study that concluded: "The greatest desire for information about sexuality among freshmen college students, black and white, male and female, shows up the deficiencies

in the sex education offered in North Carolina families and schools. The current furor being stirred up against sex education ignores the fact that it begins inevitably from birth and continues in one form or another throughout life. The question cannot be construed in terms of whether to provide sex education but only in terms of whether this instruction will be sound or unsound. To say nothing is to indicate that sex is either unmentionable or irrelevant. At present, students whose education terminates with high school have only a slim chance of entering marriage with the knowledge of the significance of sex and of techniques of family planning."

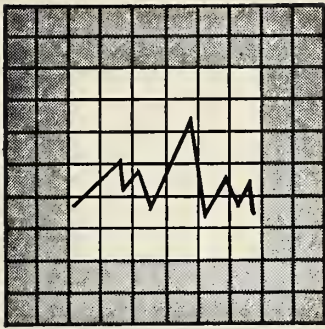
A most significant study of five thousand children kindergarten through twelfth grade by the Connecticut State Department of Education⁴ lists by grades their questions in many areas of health including sex. To continue to ignore such studies as indicate the great need and desire of our young for solid information, given by respected authority figures in our societal institutions, in support of the important and inevitable role of the family in education for human sexuality, is to admit to our own hangups in the adult generation and to belie our scientific training. ◀

References

1. Bell, Robert R., and Chaskes, Jay B. "Premarital Sexual Experience Among Coeds," 1958 and 1968. *Journal of Marriage and the Family*, Vol. 32, No. 1: 81-84, February 1970.
2. Christensen, Harold T., and Gregg, Christina F. "Changing Sex Norms in America and Scandinavia." *Journal of Marriage and the Family*, Vol. 32, No. 4: 616-627, November 1970.
3. Nash, Ethel M., and Loudon, Lois M. "The Premarital Medical Examination: What Patients Desire." *Journal of the American Medical Association*, Vol. 10, No. 13: 2365-2369, December 1969.
4. Byler, Ruth., Lewis, Gertrude., Totman, Ruth. "Teach Us What We Want To Know." New York: Mental Health Materials Center (Published for the Connecticut State Board of Education), 1969.

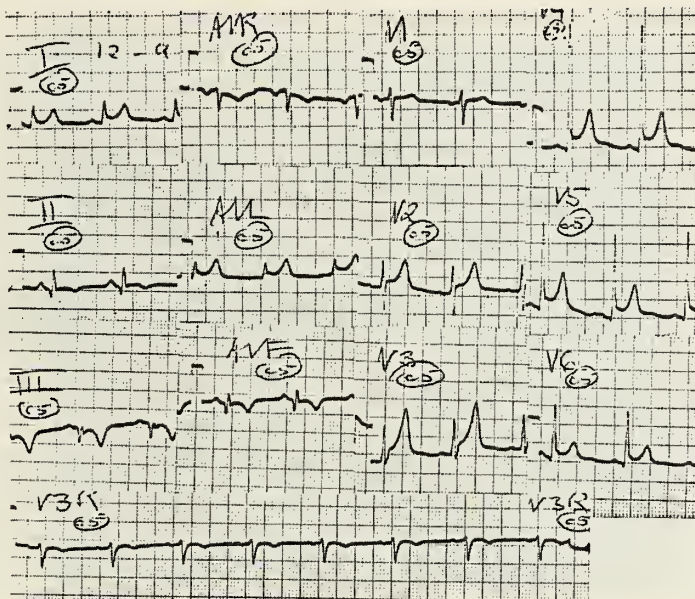
A reduction of bassinets

The declining birth rate is causing a reduction of bassinets in many hospital maternity departments, and some hospitals have closed their maternity wards entirely, according to the American Hospital Association.



ekg of the month

JOHN R. TOBIN, JR., M.D., M.S., RINGAUDAS NEMICKAS, M.D.,
PATRICK SCANLON, M.D., JOHN F. MORAN, M.D. AND JAMES
V. TALANO, M.D./SECTION OF CARDIOLOGY,
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

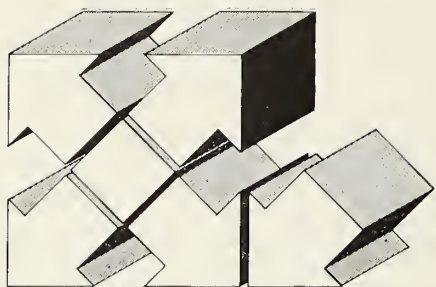


This 40-year-old man had been perfectly well until the onset of severe non-radiating retrosternal chest pain. The pain was aggravated by deep inspiration and by rotation of the trunk, and was somewhat relieved by sitting forward. Physical examination was unremarkable except for the presence of a pericardial rub.

Questions: (One or more of the choices may be correct.)

- A. The electrocardiogram suggests:
 1. Acute pericarditis.
 2. Anteroseptal myocardial infarction.
 3. Inferior wall infarction.
 4. Normal early repolarization.
- B. Regarding this type of patient:
 1. A classical pericardial rub has three components.
 2. Anticoagulants are indicated.
 3. Myocardial infarction and a pericardial rub may coexist.
 4. The natural progression of ST-T waves in pericarditis is for ST segment to return to baseline, and the T wave to invert.

(Answer on page 579)



trauma center

BY D. C. SIEGEL, M.D., GERALD S. MOSS, M.D., AND ALAN COCHIN, M.S./CHICAGO

Fluid Therapy In Hemorrhagic Shock

RESUSCITATION IN HEMORRHAGIC SHOCK involves a number of therapeutic maneuvers often carried out more or less simultaneously. These include effects aimed at ensuring adequate ventilation, control of external hemorrhage, decompression of existing hemo- or pneumothorax, and restoration of the circulating volume. A simple approach to the problem of fluid therapy in hemorrhagic shock is described.

Details of Catheter Placements

It is extremely important for several reasons that large bore catheters be used in the initial treatment of serious hemorrhagic shock. First, large bore (#14 gauge) is used so that an adequate volume of blood and fluid can be quickly administered in a short period of time. Second, catheters should be used rather than needles because the catheters do not become dislodged from their intravenous position as easily as do needles when the patient is thrashing about or being transported. Such catheters, however, are not without their drawbacks. These drawbacks include thrombophlebitis and shearing of the

catheter tip with embolus production. The former can be minimized by observing sterile techniques during vena puncture and by changing the vena puncture site every 48 hours. The problem of catheter tip shearing can be avoided by always slipping the needle "sleeve" down over the tip of the needle. If no sleeve is provided, a tongue depressor should be taped to the needle and catheter to prevent any shearing motion of the needle tip on the catheter.

The best sites for vena puncture include the external jugular veins, the antecubital veins, and the veins on the dorsum of the hands. The subclavian vein can be punctured percutaneously

beneath the clavicle and it is an excellent avenue for fluid therapy. However, such complications as pneumothorax, air embolism, and subclavian artery injury have been reported with this approach. The femoral veins can also be entered percutaneously and used for emergency fluid resuscitation. With prolonged use, this site tends to become infected and thrombosis is a real hazard.

The Optimum Fluid Volume

It is important to remember that no single index, by itself, can reliably and consistently indicate when the circulating volume has been restored. In recent years, increasing reliance has been placed on the central venous pressure to the exclusion of the more traditional physical signs such as arterial pressure, pulse rate, skin color and temperature, urine output, and sensorium. Administering fluids until the central venous pressure reaches some arbitrary level, such as 15 cm of H₂O, is not a reliable solution to the problem of how much fluid to give.¹ There is a real danger of giving too much fluid because an elevated central venous pressure is a very late sign of overload, especially if cardiac function is reasonably intact. It is much safer to give fluids until the pulse rate slows to below 100, the arterial pressure rises to a mean greater than 70 mm Hg, the skin becomes warm and dry, the urine output exceeds 30 ml/hr, and the patient becomes less anxious. The central venous pressure is most informative when it rises above 15 cm H₂O. This indicates that the heart cannot completely clear the volume of blood presented to it. In this situation, fluid therapy must stop. A low central venous pressure, on the other hand, is of no great moment and does not indicate that more fluid must be given.

Fresh compatible blood is the ideal blood substitute. Unfortunately, banked blood is very

different from that which is lost during hemorrhage. Banked blood contains citrate anticoagulant, varying amounts of ammonia and potassium, white cell and platelet antigens, and most serious of all, the hazard of hepatitis infection.² These hazards can be reduced by using packed or washed cells rather than whole blood. In an emergency these may not be practical and whole blood must be used.

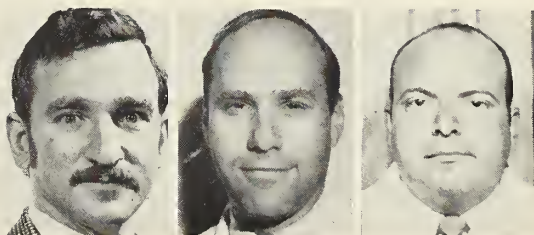
There is no precise way to know how much blood must be given during acute resuscitation. In most situations serial hematocrit readings provide the most valuable information. It is generally agreed that a reading of 30% is adequate to provide satisfactory oxygen carrying capacity. If the hematocrit falls much below this there is danger of tissue hypoxia, while levels much higher than 30% do not seem to be more beneficial during the acute emergency and do expose the patient to the hazards of unnecessary blood transfusions.

The use of universal donor blood or uncross-matched type and group specific blood should be discouraged. Universal donor blood is dangerous in non-group O recipients because of the A and B isoantibodies present in the donor plasma. These isoantibodies attack the recipient red cells producing varying degrees of hemolysis, depending on the number of transfusions given. In addition, uncrossmatched type and group specific transfusions are hazardous because if a mistake in typing occurs, an ABO incompatibility may result with serious or lethal consequences. On the other hand, numerous studies have shown that the circulation can be safely restored temporarily, at least, by asanguinous fluids alone. These studies indicate that arterial pressure, acid base balance, and urine output can be returned to normal without using blood initially. This provides for a "grace period" while careful cross matching can be done.

DONALD C. SIEGEL, M.D. (left), is an instructor in surgery at The Abraham Lincoln School of Medicine, University of Illinois College of Medicine, Chicago.

GERALD S. MOSS, M.D. (center), is an associate professor of surgery at the Abraham Lincoln School of Medicine and attending professor of surgery at Cook County Hospital. His major contributions have been in the evaluation of frozen blood and in studies in pulmonary insufficiency in shock.

ALAN COCHIN, B.S., M.S. (right), is a research associate and graduate student at The Abraham Lincoln School of Medicine, University of Illinois College of Medicine, Department of Surgery.



Fluid Therapy in Hemorrhagic Shock

Colloid Solutions

These solutions include plasma, albumin solutions, and dextran. Human plasma is an excellent plasma expander since its electrolyte and protein makeup is almost identical to the recipient plasma. The disadvantages include a high cost, limited supply, a crossmatching requirement, and the risk of hepatitis especially in pooled plasma. Fresh frozen plasma is valuable because it contains all the clotting factors except platelets.

Albumin solutions enjoy widespread use because of their similarity to plasma and the absence of hepatitis risk. They consist of 88% heat denatured albumin and 12% globulin. Many consider these to be the ideal plasma expander.

Dextran is an artificial starch solution made up in various molecular weights and at various concentrations. They possess serious potential side effects which include interference with clot formation, renal toxicity, and anaplyactoid reactions. We do not recommend their use in the treatment of hemorrhagic shock.

Electrolyte Solutions

Although a number of different solutions are available, the two commonly used solutions are isotonic saline and lactated Ringer's solution. Isotonic saline contains 154 mEq each of sodium and chloride. Lactated Ringer's is made up of 130 mEq of sodium, 108 mEq of chloride, 28 mEq of lactate, and small quantities of potassium, calcium and magnesium.

Under most circumstances, the two fluids can be used interchangeably. However, if large volumes of fluids are necessary, lactated Ringer's is preferable to isotonic saline. This is so because excess chloride as compared to plasma is found in the saline but not in the Ringer's solution. If large volumes of saline are given in the treatment of hemorrhagic shock, hyperchloremic acidosis may result, as the excess chloride displaces bicarbonate. Since the chloride concentrations in the lactated Ringer's is similar to plasma, it can be given in large volumes without producing this derangement in chloride levels.

Electrolyte Solution versus Colloid Solution

There is considerable controversy concerning the relative merits of colloid administration as opposed to electrolyte solution administration in the initial treatment of hemorrhagic shock. The colloid enthusiasts point out that the macro-

molecules in the colloid solution are crucial, since they function to maintain the infused fluid in the intravascular space, and inhibit fluid movement into the interstitium. They claim that electrolyte solution infusion has only a transient effect and promotes the development of interstitial edema, especially in the lung.

Electrolyte solution enthusiasts point out that patients suffering from hemorrhagic shock do well following initial treatment with electrolyte solution because this solution provides large amounts of sodium (which seems to be essential for recovery); promotes good urine output, thus minimizing the hazard of acute renal failure; and restores the indices of circulation to normal levels without promoting development of pulmonary edema.

We believe that either kind of solution is capable of providing a satisfactory restoration of circulation provided that the appropriate volume of asanguinous fluid is given along with crossmatched blood.³

Resuscitation from hemorrhagic shock includes providing adequate ventilation, control of external hemorrhage, decompression of hemo or pneumothorax, and restoration of circulating volume. Fluid therapy should begin with asanguinous fluids followed by crossmatched whole blood, or preferably packed or washed cells. Fluids and blood should be given until the pulse rate falls to approximately 100 beats per minute; the mean arterial pressure exceeds 30 ml/hr, the skin is warm and dry, the patients' sensorium improves. A low central venous pressure is not clinically important. A rising central venous pressure (>15 cm H₂O) indicates that the heart can no longer clear the volume of blood presented to it, and therefore the infusion should be stopped. ◀

References

1. Pulmonary effects of nonthoracic trauma: Proceedings of a conference conducted at the Committee on Trauma. Division of Medical Sciences, National Academy of Sciences, National Research Council. *J. of Trauma*, 8:625-983, 1968.
2. Prince, A. M., Szmunes, W., Woods, K. R., and Grady, G. F.: Antibody against serum-hepatitis antigen: Prevalence and potential use to prevent hepatitis. *N. Eng. J. Med.*, 285:933, 1971.
3. Moss, G. S., Proctor, N. J., Homer, L. D., et al.: A comparison of asanguinous fluids and whole blood in the treatment of hemorrhagic shock. *Surg. Gynec. Obstet.*, 129:1247-1257, 1969.



surgical grand rounds

EDITED BY JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of June 8, 1971.

Submaxillary Gland Cylindroma

Case Report:

Dr. Charles McHugh: A 22-year-old female was admitted to Chicago Wesley Memorial Hospital on March 1, 1971. She had noted a left submandibular mass approximately four years earlier during her only pregnancy. From that time she estimated that the mass gradually doubled in size. She did state that on occasion, particularly with cold weather or when it was touched, she noted a localized sharp pain or a feeling of fullness in the area of the tumor. This pain did not radiate and was not associated with any paresis. On several occasions, she received antibiotics from her own physician without effect. There was a history of known tuberculosis in her household, her father having had tuberculosis.

Positive physical findings were limited to head and neck. There was an irregular firm 1.5x1.5x2 cm mass in the left submandibular area lying medial and inferior to the body of the mandible, just anterior to the angle of the mandible. There were no overlying skin changes. This mass was mobile and could be palpated in the floor of the mouth lying at the level of the second and third molars on the left. There were no changes in the mucosa of the floor of the mouth. Both Stensen's and Wharton's ducts were normal. The remainder of the oral examination was unremarkable. Cervical adenopathy was not present. Laboratory study was within normal limits. X-rays of the chest and of the soft tissues of the neck and of the jaw were considered to be unremarkable.

Submaxillary Gland Cylindroma

On March 2, 1971, the patient was taken to the operating room where a submandibular incision was made and the left submaxillary gland was enucleated. A frozen section examination was obtained and was reported as a mixed tumor of the submaxillary gland. However, a final pathologic diagnosis of cylindroma or adenoid cystic carcinoma was made. The patient was discharged and then was readmitted on March 21, 1971. Four days later a radical neck dissection and en bloc dissection of the submandibular triangle including the floor of the mouth was performed, the mandibular ramus of the facial nerve having been sacrificed, leaving a small oracutaneous fistula in the anterior portion of the incision. This healed rapidly and she is well.

The patient was presented.

Dr. Joseph C. Sherrick: The surgical specimen showed soft pale gray moist tumor diffusely infiltrating the salivary gland (Figure 1). The tumor showed definite gland formation, and many of the glands were swollen and distorted (Figure 2). The rather dense stroma between the glands may have led to the frozen section diagnosis of mixed tumor. Perineural space invasion by this glandular tumor is clearly demonstrated in the middle of the photograph (Figure 3). The pathological diagnosis in this case is adenoid cystic

carcinoma of the parotid gland. The term cylindroma is a synonym. These are invasive tumors which may extend fairly long distances in the perineural space. Because of this tendency, they are difficult to excise completely, and recurrence is common. Distant metastasis can result.

Dr. Charles McHugh: In the differential diagnosis of tumors lying within the submaxillary triangle, one must consider first metastasis to the lymph nodes from intraoral or, rarely, nasopharyngeal cancer. Sialadenitis of submaxillary gland with or without a calculus, may be present as a mass in the submaxillary triangle. Another important possibility to consider is obviously a primary tumor of the submaxillary gland, either benign or malignant. A metastatic tumor from a distant site occasionally is seen, such as a case of a renal tumor which was recently reported.

The diagnostic procedures for lesions in the submaxillary triangle are not particularly satisfying. Examination may reveal only a firm tumor. There may be fixation, surrounding induration, or tenderness which are not enough in themselves to establish a diagnosis. Plain X-ray and Sialography may or may not reveal an abnormality. A calculus may be detected if the calcium content of the stone is sufficient to show up on X-ray films. Sialography may reveal interruption of Wharton's duct, but Sialography is not always a successful procedure. Biopsy is generally contraindicated, because with either a needle or incisional biopsy, tumor cells may be implanted in the area and this tumor, as Dr. Sherrick has mentioned, is very notorious for recurring locally. The recommended form of biopsy is total enucleation of the gland, not quite as well done in this case, but rather as a complete clean-out of the submandibular triangle taking out all the fibroadipose tissue that surrounds the gland, and sacrificing the facial artery. There is no indication on the first enucleation for removal of the other important structures in the submandibular triangle, such as the hypoglossal nerve or lingual nerve, and there should be no reason to get into the lingual veins which run with the lingual nerve. Tumors of the submaxillary salivary gland have a propensity for local recurrence. Benign mixed tumors have a tendency to extend beyond the apparent gross capsule of the gland, and it is easy to leave some cells behind when the gland is enu-



Figure 1. Submaxillary gland is diffusely infiltrated with tumor

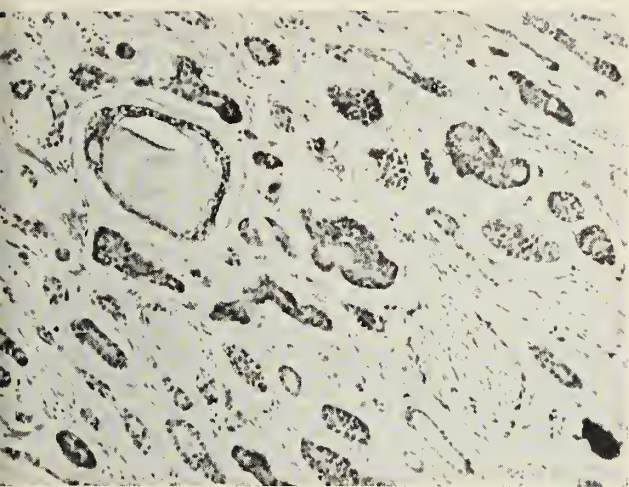


Figure 2. Microscopic study shows gland formation, characteristic of adenoid cystic carcinoma

cleated. Malignant tumors, as indicated in Dr. Sherrick's slide, may extend directly into the lymphatics. Adenoid cystic carcinoma has a tendency to extend along perineural pathways, either within the lymphatics or in perineural spaces. When these tumors are removed, frozen sections should be made immediately of all areas that may contain tumor cells, including all the nerves in the specimen. Also, the pseudocapsule of the tumor should be checked, and if extension through the capsules is found, more extensive surgery should be carried out immediately. If the diagnosis is inconclusive by frozen section or the frozen section shows no extension, the operation should be terminated. If the permanent section shows a more serious problem, as was the case in this patient, further surgery should be carried out as soon as possible—an en bloc excision, including the entire recent operative wound and a wide margin of local tissue.

In this case, we did an en bloc dissection of the submandibular triangle, including the hypoglossal nerve and the lingual nerve since we knew that there was perineural invasion, but we did not know how far the invasion extended, or which nerve was involved. The indications for radical neck dissection are somewhat controversial.

Dr. John Beal: Dr. Griffith, tell us why you chose the radical neck dissection.

Dr. Griffith: As a general rule, we do not do neck dissections unless there are palpably enlarged lymph nodes in the neck. This holds for squamous cell carcinoma in most areas, except the tongue and floor of the mouth, where a neck

dissection is usually done regardless of the presence of palpable nodes. Cylindroma is a very unpredictable tumor, and in this area, cylindromas tend to behave badly. The majority (about 75%) of tumors in the parotid are benign. On the other hand, about the same percentage of tumors in the submaxillary salivary gland are malignant, and there is a very high incidence of local recurrence and of extension to the local lymphatics. In this patient, the perineural lymphatics were definitely involved on the initial sections and the distance to the regional lymph nodes was very small. We therefore felt that the node dissection should be done. We could not really feel confident that we were beyond the margins of the tumor unless we took the nodes. We used the two parallel McFee incisions, which avoid vertical scarring. It gives good access to the neck contents and leaves very little deformity. The sternomastoid muscle was detached from the clavicle and reattached at the end of the procedure. A portion of the mandible was removed because the gland was adjacent to the underside of the mandible, and we felt that we could feel confident of getting it all out without taking part of the jaw. The previous operative wound was completely excised with the specimen. It is significant that there was tumor in the scar which resulted from the first operation. So, had we not gone back, we would have left tumor in the immediate area which undoubtedly would have recurred. The floor of the mouth was taken to be sure of getting out all of the gland and all of the duct, which of course, runs right along

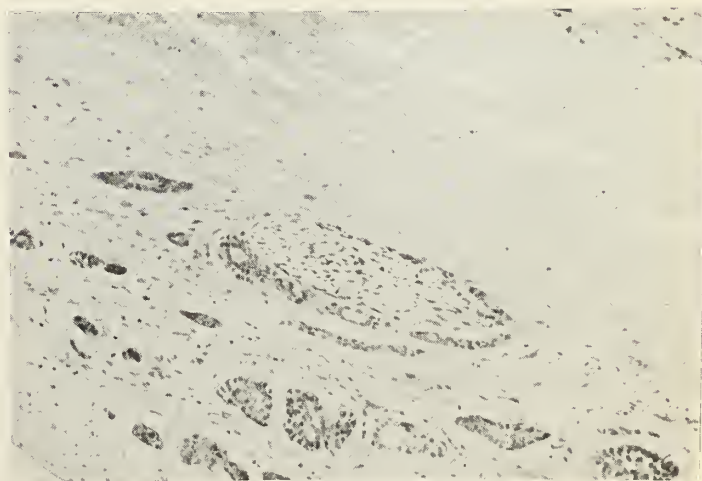


Figure 3. Perineural space invasion is demonstrated

Submaxillary Gland Cylindroma

the floor of the mouth. The defect in the floor of the mouth was repaired with a free skin graft.

Dr. Jerome Goldstein: In the New York Memorial Hospital series, 1778 patients with salivary gland tumors were reviewed. The vast majority, 1751, were single tumors. Considering all major salivary gland tumors, roughly 90% of these tumors are in the parotid gland and 10% are in the submaxillary gland. The histologic classification of the malignant tumors in this Memorial Hospital series revealed 127 malignant mixed, 138 low grade mucoepidermoid, 74 high grade mucoepidermoid, 51 epidermoid, and 216 various types of adenocarcinoma of which 71 were classified as adenoid cystic tumors. This figure of 71 adenoid cystic tumors in a collection of 1751 salivary gland tumors indicates the relative rarity of this lesion. Considering five year end results for adenoid cystic tumors, the Memorial Hospital series included 30 determinate cases involving the parotid gland with a 30% five year cure, and 34 determinate submaxillary cases with a 24% five year cure. Although we have spoken of the relative rarity of this lesion when considering all salivary gland tumors, it is interesting that in every large series, the adenoidcystic tumor is the most common malignancy involving the submaxillary gland. One fact that Beahrs makes in his series of 73 cylindromas from the Mayo Clinic is that a five year followup is not long enough to be meaningful with this tumor because so many people are alive with disease ten years or more after operation. These tumors do not tend to metastasize by nodal lymphatics but rather are notorious for their perineural lymphatic invasion.

Dr. John Beal: The role of radical neck dissection is somewhat controversial in this area. Why do you consider wide local removal inadequate?

Dr. Griffith: Because there was perineural lymphatic involvement here, and the distance from the primary lesion to the lymph nodes was very small, we felt that it was desirable to do the neck dissection. The question of whether to do this or not is really not well answered because the number of these cases is not large. Most people have done radical neck dissections because these tumors have been associated with such a bad prognosis. It is true that they may go for long periods of time. We have seen them go 25-30 years and then metastasize. We do not

have good figures to indicate that a neck dissection should not be done if the nodes are not palpable. But because of the very aggressive nature of this lesion, the fact that there may have been tumor left behind, and evidence that tumor was in the perineural lymphatics, we felt that a neck dissection was advisable.

Dr. Thomas Shields: I would like you to answer a question which has not been really discussed. When a patient has a mass in the submaxillary gland, which we can say that half the tumors are malignant and the most common one is the adenoid cystic type, how would you prefer to approach this lesion initially?

Dr. Griffith: We like to have a definite diagnosis on these patients before we go ahead with anything radical. I do not think you should do this extensive a procedure unless you are sure it is a malignant tumor. There are two ways of biopsying these tumors of course, the needle biopsy and the open incision biopsy. An incisional biopsy does cut into tumor and probably does increase the likelihood of local recurrence. A needle biopsy is likely to not give you enough tissue to make a satisfactory diagnosis. There are people who do favor needle biopsy for these tumors. They then excise the needle tract when the excision of the whole area is carried out later. This girl, of course, had a lesion which was called a benign mixed tumor on frozen section, with a large amount of tissue to choose from. Whether it would have been possible to make a diagnosis of malignant tumor on the basis of a needle biopsy is somewhat questionable. If you get a negative biopsy, you don't know any more than you did before. I personally feel that the best way of establishing the diagnosis of tumor in this location is the same as establishing the diagnosis of a parotid tumor, namely taking out the gland with the tumor. This was done here, initially with perhaps not as much peripheral tissue being taken out as one would have liked. Although I wasn't there at the first operation, I gather that it was taken out as completely as seemed feasible without taking out the mandible. I don't have any real criticism of this except to say that perhaps it might have been possible to take a little bit more of the peripheral tissue initially.

Dr. John Beal: Dr. Goldstein, do you have any comments on this point?

(Continued on page 564)

H. E. W.'s Health and Nutrition Examination Survey

Gains momentum

THE HEALTH AND NUTRITION EXAMINATION SURVEY which began its present cycle of examinations in April 1971 is now operating three separate mobile caravans and will visit 65 locations during the next two years. The object of the survey is to obtain up-to-date information on the health and nutrition levels of Americans by taking a scientific sampling, and then making the information available to the individual's physician upon their mutual request.

About 590 persons aged 1-74 years from *Cook, Kane, Will* Counties, Illinois, and Porter County, Indiana, will be invited to receive health and nutrition examinations in a study beginning July 15 and ending August 26, 1972. The examining program is part of a nationwide survey of young persons and adults conducted by the Health and Nutrition Examination Survey of the U.S. Public Health Service.

The Survey will examine a representative sample of the U.S. population over the next two years, visiting 65 locations throughout the country for this purpose. The Survey will be collecting uniform statistical information on selected chronic disease conditions and on the nutritional status of the population aged 1-74 years. Persons to be examined are selected by scientific sampling techniques and invited to participate in the data-collecting process. Examinations are conducted at the Survey's mobile examination center, which will be set up at a central location.

Each examination team consists of: a general examining physician, dermatologist, ophthalmologist, dentist, nurse, laboratory technician, two health technicians, secretary, three nutritionists, and supporting staff of administrative personnel and interviewers.

All data and information collected from those individuals participating in the Survey are used for statistical purposes only and are strictly confidential. A copy of examination findings, including laboratory findings (hemoglobin, red and white cell counts, cholesterol, iron, vitamin levels, etc.) may be made available to an examinee's personal physician or clinic physician should this be requested and authorized by the examinee. Findings of the examination are not made available to the examinee by the examining staff, but rather through his physician, who is best able to interpret the findings and possible significance of such for the individual involved.

Operationally, the survey is preceded in each area by interviewers from the Bureau of the Census, who visit the selected census tracts for the purpose of identifying the eligible persons and collecting related information. From this list of eligibles, a number of sample persons is selected and later contacted by Health and Nutrition Examination representatives, who explain the Survey, seek authorization for participation, and arrange appointments for the examination and transportation.

No charge is made for the examination and transportation provided to and from the mobile examination center. ◀

How many actually being saved from cancer?

About 217,000 Americans will be saved from cancer this year.

How many more could be saved from cancer?

About 108,000 cancer patients will probably die in 1972 who might have been saved by earlier and better treatment.

REPORT OF A CASE:

Autotransplantation of Splenic Tissue

THERE have been 51 cases of autotransplantation of splenic tissue reported in the medical literature. True incidence cannot be ascertained because it is necessary to re-examine the abdominal cavity of patients with a previous splenectomy for traumatic rupture of the spleen—either at autopsy or at subsequent surgery, and the actual incidence may be higher than that reported. Because of its interest as a diagnostic problem in the “surgical abdomen,” it seemed advisable to report the following case.

Case Report

The patient, a 29-year-old caucasian female, Gravida 1, Para 1, admitted on 3-8-71 to MacNeal Memorial Hospital with the chief complaints of left lower quadrant pain and irregular menstrual periods of four years duration. Since one year prior to admission, she had her periods at times twice a month and it lasted for seven days; at other times, it was irregular. She also had a dilatation and curettage for menometrorrhagia first day. Her last menstrual period was on 2-26-71. Menarche was at 16 years of age. Previous history revealed that she had sustained a fall from a horse at 16 years of age which resulted in rupture of the spleen and laceration of the kidney, requiring surgery and splenectomy. She had a dilatation and curettage of menometrorrhagia and evaluation of a left pelvic mass on 8-4-70. On examination at this time, the left adenexa seemed enlarged to an egg-sized soft cystic mass most likely the left ovary and easily movable. The curettings were reported as early secretory endometrium.

Physical examination at the time of admission revealed slight tenderness in the left lower quadrant. Pelvic examination revealed a retro-

verted uterus, the right adenexa was normal, the left adenexa was cystic 4 cms in diameter—and tender. Motion of the uterus produced marked discomfort. A barium enema was done and was reported as negative. The preoperative diagnosis was endometriosis and cyst of the left ovary. An exploratory laparotomy was done on 3-9-71. On opening the peritoneal cavity, the omentum was visualized and on the marginal end of the omentum, there were many “lima-bean” sized, red and somewhat soft compressible masses. These variously sized masses were also present on the serosa of the intestines. The liver appeared normal. The left kidney was atrophic at the apex, but the lower part felt normal. From the left mesosalpinx, a 1 cm mass was excised. The fallopian tubes appeared normal. On the posterior surface of the broad ligaments, there were similar masses up to 3 cm in greatest diameter that appeared to be principally over the ureteral areas. Biopsy was taken. The left ovary had several small lesions on the surface and was wedge resected. A lesion on the left sigmoid was excised and although suture ligatures were required for hemostasis, a small hematoma developed.

Surgical Pathology Department received a roughly bean-shaped, deep reddish brown, soft

tissue structure measuring 0.7 x 0.3 x 0.2 cm and a roughly ovoid irregular adipose tissue mass which resembled the omentum, measuring 8.5 x 3 x 1.2 cm within which eight deep reddish brown spherical to bean-shaped fleshy nodules resembling lymph nodes and measuring 0.2 to 1.8 cm in greatest dimension were seen—also a smooth cystic structure and a rough hemisection of the ovary which showed two minute blood-filled cysts and a few smooth-walled serous cystic structures and a corpus luteum. Microscopic examination showed multiple splenic nodules compatible with splenosis (Figure 1) paratubal cyst and follicular cysts (Figure 2) of the left ovary.

Discussion

In 1896, Albrecht¹ first noted the presence of multiple splenic nodules in the peritoneal cavity which he believed were accessory spleens. The second case was reported by Schilling² in 1907. No history of trauma was mentioned in either case. In 1910, Kuttner³ reported another case which also was thought to be accessory spleens. Faltin⁴ in 1911 reported the first case diagnosed prior to autopsy and suggested that these nodules were splenic implants rather than accessory spleens. Von Stubenrauch⁵ (1912) published a case and postulated his splenoid theory, the formation in the peritoneal cavity of organs having structure similar to the spleen, following loss of normal spleen. But the wide distribution of the splenic nodules in splenosis in the abdomen and even in the thoracic cavity is inconsistent with the embryological development of the spleen from the dorsal mesogastrium. Bushbinder and Lipkoff⁶ in 1939, coined the term "Splenosis" and reported a case of autotransplantation of the splenic tissue in a 28-year-old female patient following splenectomy for traumatic rupture of the spleen, 19 years prior to the diagnosis of splenosis.

The difference between accessory spleens and splenosis is that the accessory spleens resemble the spleen in structure and occur most commonly in the region of the hilus of the spleen, the tail of the pancreas at or near the splenic bed, whereas in splenosis the splenic nodules do not possess a hilus, the blood vessels entering at the periphery and the nodules are widely distributed. In some cases, the structure of these nodules were identical to the normal spleen, and in other cases there were paucity of the lymphoid follicles and occasional atypical blood vessel relationship. It may be that the size of the original

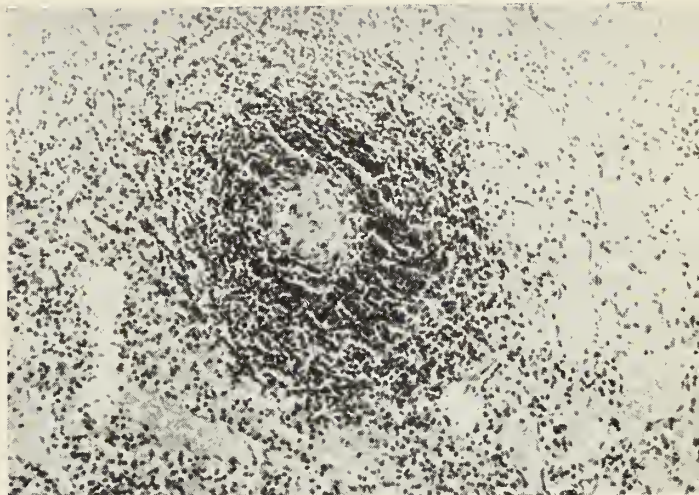


Figure 1. Photomicrograph of splenic nodule from omentum.

implant decides the degree of similarity to normal spleen.¹⁵ In our case, there were lymphoid follicles. It has been proved that it is possible to produce splenosis in experimental animals by smearing the peritoneal cavity with splenic pulp.

At laparotomy, one may confuse this condition with endometrial nodules, angiomata, carcinomatosis or sarcoma. The importance of this condition lies in the fact that when splenectomy is being done for a medical condition such as thrombocytopenic purpura, extreme care should be taken to insure that the spleen is not accidentally ruptured. McCann¹⁰ has pointed out

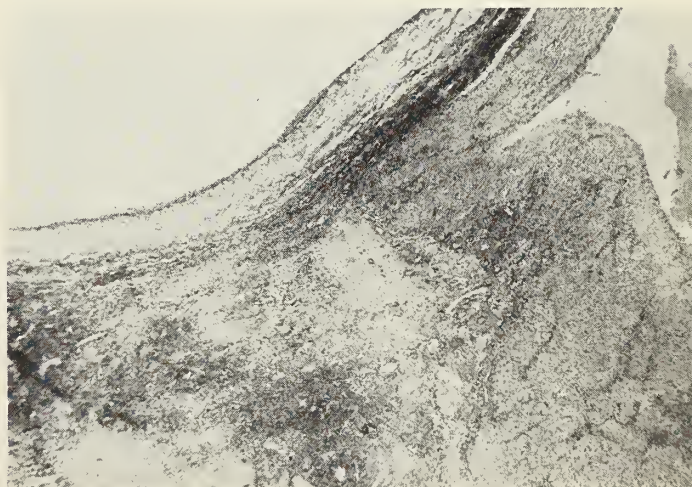


Figure 2. Photomicrograph of cyst from left ovary lined by a layer of follicular cells.

Autotransplantation Splenic Tissue

the importance of preserving an intact splenic capsule and has suggested that should spillage occur, the peritoneal cavity should be lavaged with normal saline. Stobie¹⁴ has reported a case where the condition recurred and on re-exploration, multiple splenic nodules were found.

Splenosis is usually asymptomatic, but vague abdominal discomfort may occur probably due to adhesions. A few cases of intestinal obstruction due to adhesions and two cases due to splenosis per se has been reported.^{7,8,9,16} Gammill and VonCraig¹² have described a case of splenosis mimicking a gastric neoplasm and Skinner and Hurteau¹³ refer to a splenic nodule producing an opacity in the chest X-ray for which surgery was done because a bronchogenic carcinoma could not be ruled out. A case of splenosis found at laparotomy for hematemesis has been reported by McCann.¹⁰ Maudsley and Robertson¹⁷ have reported a case of a 40 year old female patient who had lower abdominal pain, leukorrhea and some menstrual irregularities which necessitated an exploratory laparotomy, when multiple splenic nodules and endometriosis were found. The patient had a history of splenectomy for traumatic rupture of the spleen at the age of 8 years (Szabo,¹⁸ etc.). Subcutaneous splenic nodules, which were noticed 22 years after splenectomy, has been reported by Cohen.¹¹ The transplanted splenic nodules have been found to carry out some of the functions of the normal spleen in some cases. Gill¹⁵ reported a case of subcutaneous splenic nodule which increased in size during a malarial attack. Tubercles as well as iron pigments have been reported in the splenic nodules.

Summary

A 29-year-old female patient was admitted with the chief complaints of left lower quadrant pain and irregular menstrual periods of 4 years duration, and a clinical diagnosis of endometriosis was made. An exploratory laparotomy was done, and splenosis was discovered. A review of the literature is also presented. ◀

References

1. Albrecht: Ein fall von sehr, Zalreichen, uber das ganze, *Peritoneum versprengten nebenmilzen*. Beitr. z. path. anat. 20:513-527, 1896.
2. Schilling, Karl: Uber einen Fall von multiplen Nebenmilzen, *Arch. path. Anat.* 188:65-87, 1907.
3. Kuttner, H. *Diskussion: Milzextirpation und Roentgenbehandlung bei Leukemie*, *Berl. klin. Wchnschr.* 47:1520, 1910.

4. Faltin, R.: Milzartige Bildungen in Peritoneum, beobachtet 6 jahre nach einer wegen Milzrupten vorgenommen Splenektomie, *Ztschr. Chir.* 110:160-175, 1911.
5. Von Stubenrauch, Milzregeneration und Milzirsatz Verhandl, d.n. deutsch, *Ges. Chir.* 41:213, 1912.
6. Bushbinder, J. H. and Lipkoff, C. J.: Splenosis: Multiple splenic implants following abdominal injury, *Surgery* 6:927-934 (Dec.) 1939.
7. Prasad et al: Splenosis and intestinal obstruction: *J. Mount Sinai Hospital, N.Y.* 35:534-540, Sept., Oct. 1968.
8. Davis, Jr., C. et al: Splenosis: A sequel to traumatic rupture of the spleen. *Arch. Surg.* 86:523, 1963.
9. Berry, C. H. and Erdman, G. L.: Traumatic autoplasmic implants of splenic tissue, *JAMA*, 152:1227, 1953.
10. McCann, W. J.: Splenosis: Rupture of spleen with splenic implants. *Brit. Med. J.* Vol. 1, 1271-1272, 1956.
11. Cohen, E. A.: Splenosis—Review and report of subcutaneous splenic implant, *Arch. Surg.* 69:777-783, 1954.
12. Gammill, S. L. and VanCraig, H.: Splenosis, autotransplantation of splenic tissue following trauma. *JAMA*, 208: No. 8, 1387, 1969.
13. Skinner, E. F. and Hurteau, W. W.: Autotransplantation of splenic tissue into thorax. *J. Thoracic Surg.* 33:807-813, 1957.
14. Stobie, G. H.: Splenosis: *Can. Med. A.J.*, 56:374, 1947.
15. Gill, A. J.: Traumatic autograft of splenic tissue in the body wall. *J. Lab and Clinical Medicine*, 29:247-253, 1944.
16. Cotlar, A.M. and Cerise, F. J.: Splenosis: The autotransplantation of splenic tissue following injury to spleen, *Annals of Surg.* 149:402-413, 1959.
17. Maudsley, R. F. and Robertson, E. M.: Splenosis: Report of a case, *Obstet. & Gyn.* 26:486, 1965.
18. Szabo, A.: Splenosis: The autotransplantation of splenic tissue, *Amer. J. Surg.* 101:208-214, 1961.



VILASINI D. JAYARAMAN, M.D., is the assistant pathologist of St. Anne's Hospital, Chicago, and was formerly senior resident, pathology, MacNeal Memorial Hospital, Berwyn, Illinois.



R. DAVID SCHREIBER, M.D., received his M.D. from the University of Maryland School of Medicine and is senior attending physician in obstetrics and gynecology at MacNeal Memorial Hospital.



BENJAMIN H. NEIMAN, M.D., received his degree from Rush Medical College, Chicago. He is director of Laboratory Sciences, MacNeal Memorial Hospital, Berwyn, Illinois, clinical professor of pathology, Chicago Medical School, and attending pathologist at Cook County Hospital.

BY ROBERT R. HARTMAN, M.D./JACKSONVILLE

Maternal death study

Case report No. 4

The fourth in a series of case reports

ONE OF THE FUNCTIONS of the ISMS Committee on Maternal Welfare is to analyze the causes of deaths in Illinois mothers and to determine, if possible, what alterations in management and treatment could have prevented any of these deaths. Each month a case will be presented and discussed in an attempt to promote more modern methods of obstetrical management. It is with extreme gratitude that the assistance of the Illinois Department of Public Health is acknowledged. Without their initial collection and preparation of the cases and protocols these studies would be very limited.

Case Report:

This patient, a 43-year-old white para VI Gravida V, was admitted to the hospital approximately one month prior to her estimated date of confinement because of uncontrollable diabetes. She had been previously admitted and had responded to medical treatment about one month earlier. On examination, the patient measured 64 inches in height and weighed 165 pounds. Her blood pressure was 180/110; pulse was normal. Laboratory work revealed a 40 hematocrit and a 12.6 gram hemoglobin with a 1300 white count. Urinary protein 350 mgm., no glucose, no casts. X-ray of the abdomen revealed "fetus smaller than estimated date of confinement would indicate." No mention of distal femoral epiphyses was made.

It was elected to postpone delivery for at least a week in order to "get a bigger baby." Blood pressure rose to 210/130. For the next three days urine continued to run 3+ albumin, the patient receiving 2000 calorie diabetic diet, 40 units of regular insulin, and 10 cc of 50% magnesium sulfate intramuscularly daily. Blood sugar rose to 540; and the urea nitrogen, which had previously been reported at 16, now was reported at 36. On the fourth hospital day the fetal heart tones were lost and the blood pressure fell to 160/90. Insulin dosage was increased

to 60 units. The following evening at 6:00 p.m. the patient had a convulsion, and her blood pressure was recorded at 230/140.

A retention catheter was inserted into the bladder and 20 cc of "dark bloody urine" obtained. Urine negative for sugar and acetone. Her sclera were noted to be icteric and the patient began to have a few contractions. An infusion containing 10 units of Syntocinon in 500 cc of "balanced electrolytes" was begun, and four hours later she spontaneously delivered a macerated 4 pound infant. During her labor the patient had received oxygen, 15% magnesium sulfate, and 50 units regular insulin. Blood sugar taken at the time the intravenous fluids were started was recorded as 1050. No urinary output was noted subsequent to initial catheterization. Placenta delivered by Crede with a moderate amount of postpartum hemorrhage. Patient remained comatose and expired 75 minutes post-partum.

Anatomical diagnosis:

1. Diabetes mellitus.
2. Severe nephrosclerosis with generalized atherosclerosis and papillary necrosis of the kidney.
3. Multiple hemorrhage noted in liver and spleen.

(Continued on page 560)

Maternal Death Study No. 4

It was the opinion of the Maternal Welfare Committee that this case represented Kimmelstiel-Wilson's disease aggravated by a pregnancy; and therefore, death was only indirectly obstetric. Yet it seemed regrettable that a woman with this severe degree of diabetes, who had most certainly contributed more than her share of children carrying at least a recessive trait for this disease, should have been allowed to continue to put her life at hazard. The second common error noted in this case is the tendency to procrastinate to get a good baby

when there is some logical explanation for the child not maturing properly. In this instance, kidney disease was no doubt the cause of malnutrition of the fetus; and allowing the child to remain in a hostile environment certainly did not improve its chances for survival. The same situation is sometimes seen where there is evidence of intraovular infection and ruptured membranes. There seemed no doubt that procrastination in the face of a worsening patient indicated that medical management played a role in the demise of both mother and fetus. ◀

The identity crisis

. . . The other day I participated in a meeting at which four social scientists met with 12 marketers to talk about the impact of the social sciences on the world of business. One of these men was a sociologist, and I thought he was the most interesting of the group. He said that taking place in the world today are changes that can be hinged to one thing—mankind's great crisis for the individual, a search for self-identity. The young are seeking self-identity and worth for themselves. The middle-aged, represented by you and me, are seeking the identity of their peers—recognition for performance and achievement. And the elderly are seeking self-worth because they live in a society which is throwing away their wisdom, their judgment, and their experience. And with the identity crisis, he said, comes the problem of rejection or challenge of our institutions: our education, our churches, our religions, our family life, and all the things taking place around us. He said that if there is one term that will mean the most for the world in relation to humanism in the next decade, it is "life style," and that everything that man does—his manner of dress, his music, his actions—will be keyed to his innovations in the area of life style. (Walter H. Johnson, Jr.: "The Anatomy of Change," *North Carolina Medical Journal*, April, 1971, pgs. 141-146.)

Medical Education in the Boonies

The main concern today of WHO (World Health Organization) in the field of education is the rapid provision of sufficient trained manpower to meet the health needs of the community. The emphasis is mainly on the developing countries, where the gap between existing and required health staff is very great. Ideally, the primary care of the patient should be by a doctor, and where the doctor/patient ratio is high this is current practice. But compare the situation in the USA, which has one doctor for 650 population, with that in Ethiopia, with one doctor per 65,000. It is evident that, in view of the long training course required to produce a physician, it will be many years before sufficient doctors are available to cover primary health care in the majority of developing countries. The primary responsibility for individual and community health care therefore devolves on the auxiliary who, with a lower basic education and a shorter training course, can be produced much more rapidly than the physician. For this category of trainee, language and literacy difficulties, combined with the frequent absence of suitable textbook and reference material, make the use of appropriate audiovisual material as an aid to learning essential. The scope is limited in that many schools for the training of lower-grade auxiliaries have no electricity supply. Even in medical facilities, variable voltages and the absence of good maintenance facilities preclude the use of all but the simplest and most robust of audiovisual equipment and materials. (M.A.C. Dowling.: *Audiovisual Media in Health Teaching*. *WHO Chronicle* (Jan) 1972, pgs. 3-6)



practice management

"How to Fire an Aide Gracefully"

BY KURT BENNETT, CONSULTANT
PROFESSIONAL BUSINESS MANAGEMENT, INC.
67 EAST MADISON STREET, CHICAGO, ILLINOIS
(312) 782-2282

It's the point of no return. You've tried to correct the situation without success. She hasn't committed a crime; she is just incapable or unwilling to do the job properly.

The decision to let an employee go is an agonizing one to most of us. Yet, occasionally, that decision must be made. There are only two things to do:

First: admit you were wrong in hiring her or in letting an intolerable situation develop.

Second: Do it!

Keeping her doesn't make sense because she's a liability to you, not an asset. Nor is it fair to your other employees. They're the ones who have to clean up the mess she makes or handle part of her share of the load. And it isn't fair to her either. She might excel in some other type of work or with a different doctor.

Office Morale A Problem?

Afraid of the morale in your office after letting a girl go? Don't be. The effect may be beneficial. Those girls, the good ones, will probably respect you because you've recognized what they have known for a long time—that they have been

doing her work. The new girl you hire will probably be better than the one you let go, since she will be exposed only to the enthusiasm of your best people.

There's usually no need to be cruel in firing. Establish a reason for termination that allows her to "save face," providing she's committed no serious misconduct. Let her leave with as few scars as possible. If the termination is violent, there is greater probability that she'll "bad mouth" you for the rest of her life or perhaps file an unemployment compensation claim out of spite. A stormy confrontation should be avoided. *That* could have a detrimental effect on your other people by leaving them with the impression of your lack of reasonableness. The emotion generated by two people in heated argument is usually transferred to others, resulting in their taking sides. Remember that in most cases a calm atmosphere will let reason prevail from the onset—not from the aftermath.

Giving the Reasons Why

One time-honored and effective approach is

How to Fire an Aide

to tell her that her combination of skills isn't what you need. This takes considerable thought in arranging your presentation so you can point out some of her good qualities or interests that might be transferable to some other type of job. You shouldn't hesitate to point out, in a factual manner, her deficiencies.

Another approach is to tell her you are restructuring her job or all the jobs in the office in such a way that you will need a girl with more experience in skills she doesn't have—whether you're really planning it or not. Be specific and be certain she doesn't have those skills! Lying? Yes, but. The Machiavellian Principle of the end justifying the means seems applicable.

Similarly, you could tell her that her job is being eliminated. In fact, give the substance of that statement some serious consideration. By paying your existing girls more to assume the workload, you may end up getting the job done at less cost. If you use these approaches or similar ones and the parting is relatively amicable, try to give her the opportunity to resign. It hasn't worked out—don't try to punish her. Of course, much of this nasty business of terminating employment of a new employee can be eliminated if you carefully tell her at the beginning:

1. What is expected of her.
2. Your personnel policies.
3. That the first three months are a trial period for both of you—for you to see how she fits in and for her to see if she likes it there. Her understanding that employment is a two-way street will do wonders for easing tensions and for your better evaluation of her.

Evaluate her progress at one week intervals during the first month, then at the end of the second month and third month. If it doesn't work out, tell her anytime in the first three months. Be cautious in evaluating the work of a new girl. Many a slow starter can become a "star." Just as many whirlwinds fizzle. In case you hired her from an employment agency, insist on a one month free trial. Agencies will negotiate rather readily. You'll discover those girls who obviously won't work out in a month. Hidden problems should surface within three months.

When you find the girl who is good, treat her like a queen.

Avoiding a Scene

What if you can't avoid a violent confrontation in firing a girl? Try to arrange the firework display after nearly everyone has left the office. Have one witness. In any event, quickly help her clean out her desk, help her on with her coat, take her office key, and change the lock immediately.

Don't ever try to force a girl to leave by indirect pressure or conduct. Surely a physician who has armored his psyche against the pains of death can tell a girl that her services are no longer needed.

The often quoted two weeks severance pay is not a rule that should dictate whether you give any severance pay; nor, should it dictate the amount. Instead, follow your conscience and the circumstances. If your conscience tells you that much of the fault is yours, give her one or two weeks pay. If it's not your fault, don't. You legally owe her nothing. It might be wise to consider giving some severance pay for another reason. Just like settling a nuisance law suit, some severance pay might buy you freedom from a lot of grief.

1. A new girl on trial gets nothing but her salary to date.
2. For an older employee, determine exactly what she has coming under your personnel policies, such as accrued vacation pay. Add any severance pay you decide upon according to your conscience.

Lastly, talk the situation over with your professional business consultant. He might have some thoughts or experiences that are helpful.

Heart Association Offers Booklets

Doctor:

For your *Stroke Patients* the following booklets are available:

APHASIA AND THE FAMILY
DO IT YOURSELF AGAIN
STROKE—A GUIDE FOR THE FAMILY
STRIKE BACK AT STROKE

call or write the
Chicago Heart Association
22 West Madison Street
Chicago, Illinois 60602
346-4675



editorials

EAT WHAT YOU LIKE!

Diets have played an important role in the treatment of many diseases. But the medical profession has never subjected diets to controlled trials as they do drugs. After all, the effectiveness of drugs or diet may be the same that occurs when a placebo is given. If used at all, they should be prescribed for a limited time only.

The irritable or spastic colon often responds to any new treatment. Improvement proves nothing. Several years ago this author queried seven internists on the diets they recommended. One did not believe in diets and another suggested a very strict regimen with a list including a few pureed vegetables, a canned peach, and baked, broiled, or boiled chicken. The rest of the physicians had diets that were so overlapping that we reached no conclusions. Food forbidden on one list was allowed on another list and vice versa.

We know that there is more to the treatment of spastic bowel than diet. Attention should be directed to the basic cause of the condition. The exception occurs when the patient knows that certain foods produce abdominal pain or diarrhea. He has an allergy or idiosyncrasy to these items. And yet, it has been said that 'alleged' allergy to certain foods usually is rooted in the psyche and not the gastric mucosa.

The individual with a malabsorption syndrome

finds that certain foods are indigestible. Diabetes also is treated on a dietary basis. I am always amazed how quickly the individual with peptic ulcer obtains relief with antacids and a diet. Given a choice between the two measures, most physicians would select the antacids. Uricosuric drugs are so effective in gout that a strict diet seldom is necessary. Why do we prescribe a low fat diet for those with gallbladder disease unless lipids upset them or they are obese? After all, fats drain the gallbladder. And there is new evidence that the bland diet for diverticulosis may do more harm than good. The dietary treatment of hypercholesterolemia also is well-known.

Some people are obsessed with what they eat. They have been known to consult a list of forbidden foods every time they sit down to a meal. Now and then elderly people are given menus requiring a complete change of dietary habits. This often upsets them and makes them unhappy.

And our worst offenders are rotund physicians who eat as though there were no tomorrow. Yet they have no conscience when they deprive others of the enjoyment of eating and the culprits probably sleep like a log. ◀

T. R. Van Dellen, M.D.
Editor

(Continued on page 564)

Guest Editorial

(Continued from page 563)

The Absent Constituency

All of medicine's current problems have occurred as a result of our own errors of commission or omission. Not always on the part of its leaders, but mostly on the part of those too busy or too uninterested to participate in shaping their future. Yet how vocal is the non-participant when those he didn't elect take a stand contrary to his individual desires or beliefs. Often the easiest recourse is to resign from the organization in protest, which at least makes his separation legitimate, and assures lack of representation.

It is very easy to criticize those who are active, but it is very difficult to be active, trying to speak for a constituency that is conspicuous by its absence, and that makes its views known only after the fact. How can the leaders in medicine be representative if their membership fails to give them clear-cut mandates. It is high time to admit that "organized medicine" is fragmented into groups, each representing only a small proportion of physicians, or better to admit that doctors really don't participate in matters very far beyond their own close personal interests.

Medical societies can be strong, responsive, innovative, and vigorous forces for the common good, but only if they can speak with the authority of numbers and units. Medical societies cannot be representative until the membership

assumes its responsibility to participate, debate, and decide issues in the democratic tradition, willing to subjugate individual parochialism to the greater good of the profession and the people it serves.

Unless the medical profession can demonstrate by performance its desire to secure new equitable, dignified solutions to the problems pressing upon us all, we will remain suspect in the eyes of the public. Such performance can only spring from a truly representative body acting in accordance with positions determined through deliberation. We cannot be representative without the majority of our membership voicing its opinions and desires in open forums. Until that happens, however, there is little justification for us to criticize those who, often by default, have the energy and integrity to push their own programs in the name of organized medicine. If we are truly to make progress, we must all show up, speak out, and secure the representative leadership and action we so desperately need and deserve. ◀

James S. Todd, M.D.
President of the Bergen
County (N.J.) Medical Society

Reprinted with permission from the American Medical News, April 10, 1972 issue.

Submaxillary Gland Cylindroma

(Continued from page 554)

Dr. Jerome Goldstein: I think there is no place for a needle biopsy because of the difficulty the pathologist had here even with a large piece of tissue. Although the preoperative diagnosis here was a benign tumor, in retrospect, the pain that she had is unusual for a benign submandibular tumor. The treatment is, I think, as has been done in this case, removal of the entire gland with the overlying lymph nodes. If the pathologist cannot identify the true nature of the tumor on the frozen section, I think one can do nothing else but what was done here.

You certainly would not resect lingual or hypoglossal nerves if you did not have a clear cut diagnosis of malignancy. One could debate whether to do anything further when the final diagnosis was made or just observe the patient. With a tumor as large as this, I would have done as Dr. Griffith did with the upper neck, but there is some question in my mind as to whether I would have taken the internal jugular vein and the lymph nodes in the lower neck. But we are talking about a tumor with a five year survival in the range of 20%, so, I think it's very difficult to criticize one for being too thorough. ◀



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals Drugs not previously known, including new salts.

Duplicate Single Products Drugs marketed by more than one manufacturer.

Combination Products Drugs consisting of two or more active ingredients.

New Dosage Forms Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

ANCOBON Fungicide-systemic R

Manufacturer: Roche Laboratories

Nonproprietary Name: Flucytosine

Indications: Serious infections with *Candida* and/or *Cryptococcus*.

Contraindications: Hypersensitivity

Warnings: Use with extreme caution in pts. with impaired renal function and/or bone marrow depression. Safe use during pregnancy has not been determined.

Precautions: Close monitoring of patient's hematologic and renal status and liver enzyme levels.

Dosage: 50 to 150 mg./kg./day at 6 hrs. intervals.

Supplied: Capsules, 250 mg. and 500 mg.

HALOTEX Fungicide-Topical R

Manufacturer: Mead Johnson

Nonproprietary Name: Haloprogin

Indications: Tinea infection with *Trichophyton rubrum*, *Trichophyton tonsurans*, *Trichophyton mentagrophytes*, *Microsporum canis*, and *Epidermophyton floccosum*, and *Malassezia furfur*.

Warnings: Safety for use in pregnancy has not been established. Keep out of eyes.

Dosage: Apply to affected area twice daily for 2 to 3 weeks.

Supplied: Cream, 30 gm. tube 10 mg. per gm. Solution, 10 cc. and 30 cc. bottle contains 10 mg. per cc.

DUPLICATE SINGLE PRODUCTS

BACARATE Antiobesity Prep.-Other R

Manufacturer: Tutag

Nonproprietary Name: Phendimetrazine tartrate

Indications: Management of exogenous obesity

Contraindications: Advanced arteriosclerosis, mod. to severe hypertension, hyperthyroidism, major coro-

nary artery disease, cardiac decompensation, hypersensitivity, agitation, unstable emotions, and during or within 14 days after receiving monoamine oxidase inhibitors.

Warnings: Do not exceed recommended dosage. Do not drive or operate hazardous machinery. Not for children under 12. Safety for use during pregnancy not established.

Precautions: Mydriatic effect may be deleterious in early glaucoma.

Dosage: 1 tablet 2 or 3 times daily, one hour before meals.

Supplied: Tablets, 35 mg.

BACTOCILL Penicillin Deriv. R

Manufacturer: Beecham-Massengill

Nonproprietary Name: Oxacillin Sodium

Indications: Infections due to penicillinase-producing staphylococci demonstrated to be susceptible to sodium oxacillin.

Contraindications: Known sensitivity to penicillin. Safety for use during pregnancy has not been established.

Dosage: Adult: 500 mg. every 4-6 hrs. for minimum of 5 days.

Children weighing more than 40 kg.: adult dose.

Children less than 40 kg.: 50 mg./kg./day in equally divided doses at 6 hrs. intervals for at least 5 days.

Supplied: Capsule, 250 and 500 mg.

BROPHYLLINE Xanthine Deriv. R

Manufacturer: Tutag

Nonproprietary Name: Theophylline

Indications: Bronchial asthma, bronchospasm associated with emphysema, cardiac asthma and associated cardiopulmonary conditions and short term diuresis.

Contraindications: Hypersensitivity to theophylline

Warnings: Combination with ephedrine and like drugs may produce excessive C.N.S. stimulation. Use with caution in pts. with severe cardiac, renal, or hepatic disease, hyperthyroidism, glaucoma, or severe myocardial damage.

Dosage: Adult: 1 granucap every 12 hrs.

Supplied: Granucaps, 325 mg.

CATARASE Enzyme R

Manufacturer: Smith, Miller and Patch

Nonproprietary Name: Chymotrypsin

Indications: Enzymatic zonulysis in intracapsular lens extraction

Contraindications: High vitreous pressure and gaping incisional wound. Congenital cataracts. Patients under age of 20.

Warnings: Should not be autoclaved. Only use fresh Instruments free of disinfectants.

Dosage: Irrigate the posterior chamber with about 1-2 cc.

Supplied: 2 cc. univial.

NATOPHEROL Vitamin o.t.c.

Manufacturer: Abbott

Nonproprietary Name: Vitamin E

Indications: As a dietary supplement

Dosage: 1 capsule daily

Supplied: Capsules, 100 I.U.

SK-ERYTHROMYCIN Antibiotic—B&M Spectrum R

Manufacturer: Smith, Kline, and French

Nonproprietary Name: Erythromycin stearate

Indications: Infections caused by susceptible organisms.

Contraindications: Known hypersensitivity

Warnings: Safety for use in pregnancy has not been established. Use with caution in pts. with impaired hepatic function.

Dosage: Adults: 250 mg. every 6 hrs. Children: 30-50 mg./kg./day in divided doses.

Supplied: Tablets, 250 mg.

VITAMIN E Vitamin o.t.c.

Manufacturer: McKesson

Nonproprietary Name: Vitamin E

Indications: As a dietary supplement

Dosage: 1 tablet daily

Supplied: Chewable tablets, 100 and 200 I.U.

COMBINATION PRODUCTS

QUIBRON PLUS Bronchodilator R

Manufacturer: Mead Johnson

Composition: Each capsule contains:

Theophylline (anhydrous)	150 mg.
Glyceryl guaiacolate	100 mg.
Ephedrine HCl	25 mg.
Butabarbital	20 mg.

Indications: Symptomatic treatment or prophylaxis of bronchial asthma, asthmatic bronchitis, and related conditions with bronchospasm.

Warnings: May be habit forming. Do not administer more frequently than every 6 hrs. or within 12 hrs. after rectal dose of any preparation containing theophylline or aminophylline. Do not give other drugs containing xanthine derivatives concurrently.

Dosage: Adults: 1-2 capsules 2-3 times daily
Children 8-12: 1 capsule 2-3 times daily

Children under 8 Elixir recommended

Supplied: Capsules

KLORVESS Hyperkalemic R

Manufacturer: Dorsey

Composition: Each effervescent tablet contains:

Potassium chloride	1.125 gm.
Potassium bicarbonate	0.5 gm.
1-lysine HCl	0.913 gm.

Indications: Prevention or correction of potassium depletion

Contraindications: Severe renal impairment and hyperkalemia from any cause.

Dosage: Adults: 1 tablet completely dissolved in 3 to 4 ounces of cold water 2 to 4 times daily. Take with meals and sip slowly over a 5 to 10 minute period.

Supplied: Effervescent tablets

NEW DOSAGE FORMS

BACTOCILL Penicillin Deriv. R

Manufacturer: Beecham-Massengill

Nonproprietary Name: Oxacillin Sodium

Indications: Infections due to penicillinase-producing staphylococci shown to be susceptible to sodium oxacillin.

Contraindications: Known hypersensitivity to penicillin. Use during pregnancy has not been established.

Dosage: Adult: 250 to 500 mg. every 4-6 hrs.

Children: 50 mg./kg./day in equally divided doses at 6 hrs. intervals.

Children more than 40 kg.: adult dose.

Supplied: Vial, 500 mg. and 1 gm.

BROPHYLLINE INJECTION Xanthine Deriv. R

Manufacturer: Tutag

Nonproprietary Name: Dyphylline

Indications: Bronchopulmonary insufficiency due to bronchitis, emphysema, bronchial asthma, pneumonitis, and cardiac dyspnea. As diuretic in paroxysmal dyspnea secondary to acute left ventricular strain and other coronary artery diseases.

Contraindications: Hypersensitivity. Not to be used in conjunction with ephedrine or similar chemicals.

Warnings: Not for I.V. use. Dosage should not exceed 3 mg./lb.

Dosage: I.M. only. Adults: 250 to 500 mg. slow I.M.

Children: 2-3 mg./lb. daily in divided dose.

Supplied: Vials, 10 cc.

Each cc. contains dyphylline, 250 mg. and Benzyl alcohol, 5%.

LASAN 1 Dermatological Prep. R

Manufacturer: Stiefel

Composition: Anthralin (NF) 0.1%

Lassar's Paste

Zinc oxide

Corn starch

White petrolatum

Indications: Psoriasis

Supplied: Ointment

SERENTIL Ataraxic R

Manufacturer: Sandoz

Nonproprietary Name: Mesoridazine

Indications: Schizophrenia, behavioral problems in mental deficiency and chronic brain syndromes, alcoholism-acute and chronic, and psychoneurotic manifestations.

Contraindications: Severe C.N.S. depression or comatose states from any cause. Hypersensitivity.

Precautions: Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. One case of transient granulocytopenia has been reported.

Dosage: Dependent on conditions treated.

Supplied: Concentrate; Mesoridazine, 25 mg./cc.

what goes on

a guide to continuing education

June 16-27—Indiana University, Institute for Sex Research

Summer Program in Human Sexuality

General lecture course in human sexuality, workshops in sex education and counseling and informal small group discussions. Certificate of Attendance.

Fee: \$325, including housing.

Contact: Summer Program, Institute for Sex Research, Bloomington, Indiana 47401.

Indiana University, Bloomington, Indiana

June 17—The Council on Health Manpower-American Medical Association

Bringing People and Services Together

To assess the extent of geographic and specialty manpower maldistribution in relation to health service needs. To critically examine approaches to alleviation and to chart new directions for action at national, state and community levels.

Pre-Registration and additional information may be obtained by contacting the AMA Department of Health Manpower, 535 N. Dearborn Street, Chicago, Illinois 60610.

A large black rectangular graphic with the word "Ampicillin" written vertically in a large, white, stylized font. To the right of the word, the text "Beecham found it, named it, put it in your hands." is written in a smaller, white, sans-serif font.

Prescribe
the discoverer's brand
Totacillin^{®*}
(ampicillin trihydrate)

*capsules equivalent to 250 mg. and 500 mg.
ampicillin, for oral suspension equivalent
to 125 mg./5 cc. and 250 mg./5 cc. ampicillin.

BMP

Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620

Twenty-two Clinics for Handicapped Children Scheduled in July

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will conduct eighteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be four special clinics for children with cardiac conditions. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want an examination or consultative services.

July—

- 5 Hinsdale—Hinsdale Sanitarium
- 6 Sterling—Sterling Community Hospital
- 6 Flora—Clay County Hospital
- 11 Peoria—St. Francis Hospital
- 11 E. St. Louis—Christian Welfare Hospital
- 12 Joliet—St. Joseph's Hospital
- 12 Champaign-Urbana—McKinley Hospital
- 13 Springfield—St. John's Hospital
- 13 Macomb—McDonough District Hospital
- 13 DuQuoin—First Methodist Church
- 14 Chicago Heights Cardiac—St. James Hospital
- 18 Quincy—Blessing Hospital
- 18 Rock Island Area General—Moline Public

Hospital, Moline, Ill.

- 20 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 20 Decatur—Decatur Memorial Hospital
- 24 Peoria Cardiac—St. Francis Hospital
- 25 Peoria General—St. Francis Hospital
- 25 Belleville—St. Elizabeth's Hospital
- 26 Elgin—Sherman Hospital
- 26 Rockford—St. Anthony's Hospital
- 26 Centralia—St. Mary's Hospital
- 28 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

"Big Daddy" Government

The first (i.e., things which constitute the anatomy of change) is "government." The year 1966 will go down in history as the year in which government discovered that the word "consumer" is synonymous with the word "voter." For the remainder of our lives we will live in a world where political reality will give increasing importance to the consumer—whether patient or buyer—and the role of government in relation to people will grow, will become more ponderous, and will become more difficult.

Now this, like many things in our society, is an import. It originated in Western Europe, where today more than nine countries have consumer protection officials at cabinet or ministerial levels. It makes no difference that the consumer has evidenced no great zeal to be protected, nor does it matter that he has shown again and again a complete indifference to some of the principles of protection which are being forced upon him. The political atmosphere will not change, and for the rest of our lives government will be a partner of the professions and of business, looking over our shoulders into everything we do. (Walter H. Johnson, Jr.: "The Anatomy of Change," *North Carolina Medical Journal*, April, 1971, pgs. 141-146.)

June 17—American Medical Association

A Seminar on the Quality of Life: Drug Abuse, Venereal Disease, Violence and Aggression

Those attending will listen as well as participate in this one-day meeting focusing on these problem areas seriously affecting and jeopardizing the development of young people. You will hear about the scope of each problem . . . its medical aspects. About the social issues and processes contributing to its existence. In the process, you will have the opportunity to absorb more input on the values and attitudes of today's youth.

Contact: Quality of Life Seminar, Special Projects Department, American Medical Association, 535 Dearborn Street, Chicago, IL 60610
Glide Memorial Chapel, San Francisco, Calif.

June 18-22—American Medical Association

AMA Annual Convention-Seven Postgraduate Courses

Seven Postgraduate courses will be offered at the AMA's 121st Annual Convention in San Francisco. It marks the first time that postgraduate courses have been presented only at AMA clinical conventions. Courses to be offered: Acute Respiratory Failure, Anorectal Diseases, Antibiotics, Common Dermatoses, Experimental Learning, Hand Surgery and Liver Diseases.

Registration Fee: \$25

Contact: American Medical Society
AMA Annual Convention, San Francisco, California

June 19-20—The Eleventh Annual Professional Conference of the American Society of Safety Engineers

"Managing Occupational Health Exposures and Fire Protection"

The first section of the conference will deal with Fire Protection Aspects. The moderator will be Gerald L. Maatman, President, National Loss Control Service Corporation.

The second section, the Occupational Health Aspects will be presided over by Frank L. Paschal, Jr., Bio-Environmental Administration, General Dynamics.

A two-hour roundtable session will be held after all papers are presented. Contact: Henry H. Cox (312) 692-4121.

Executive Inn, Louisville, Kentucky

June 20—American Medical Association

The Conference on Long Term Care

Issues to be covered: Potentials of physician leadership and support of the multidisciplinary team. Uniqueness of each stroke patient, with his own residuals, potentials and needs, and ways in which the patient who is "down and out and defeated" can benefit from the proper environment and support.



**Carbenedi
Gillin**

Beecham found it,
named it,
put it in your hands.

Prescribe
the discoverer's brand
Pyopen^{®*}
(disodium carbenicillin)

*vials for injection equivalent to 1 gm.
and 5 gm. of carbenicillin.

BMP

Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620



Treatment of hypertension with drugs can be dangerous

May 5, 1972

The Editor:

In an article on hypertension (*Mod. Med.* 39:94, Nov. '71) Dr. Gantt states that there is scant evidence that mild hypertension is benefited by hypotensive drugs, but insufficient emphasis was put on the toxicity and dangers of hypotensive therapy.

Medicine is slowly learning that the products of test tube and crucible are deadly to the human organism. Overtreatment with drugs is taking an unnecessary toll of human life. Of 53,000 exposures to drugs, Doll showed that 5% had reactions that were often a threat to life and 0.1 of one percent died. The immediate effect of drug therapy may be salutary, such as a fall in blood sugar or blood pressure (BP), but the late effects may be serious.

According to the poll taken by *Mod. Med.* there were in 1969 probably 25 million under treatment for hypertension, mostly with hypotensive drugs. Based on observed deaths by Breckenridge et al due to side effects of such drugs, this could mean the loss of 5000 lives a year in the U.S. alone. However, a much greater rise in mortality could result from an increase in deaths from myocardial infarction (MI) where the hypotensive drugs are suspect. Smirk and Hodge reported a 48% increase (*Brit. M. J.* 2:1221, 1963) and Breckinridge et al a four fold increase in deaths from MI as compared to controls. The thiozides and ganglion blockers along with other drugs were used (*Quart. J. Med.* 39:411, 1970). It is noteworthy that the most

recent figures by the National Center for Health Statistics for mortality in men in 1957-68, have turned upward again. This is the same period when the thiozides and other hypotensive drugs came into wide use and the numbers taking them for these symptoms very greatly increased.

There is an important difference in the way mild and severe hypertension react to hypotensive drugs. Severe hypertension is benefited, but there is little if any such evidence for mild hypertension. The World Health Organization in its 1962 report #231 states that the use of hypotensive drugs in mild hypertension "are unnecessary and ineffective." Most cases of hypertension are now of the mild type (op. cit.); unfortunately the physician is urged to use chemotherapy, chiefly thiozides in their treatment.

In mild hypertension, death from MI is 6 times as frequent as for stroke and accounts for 55% of all deaths. (*Arch. Int. Med.* 103:98, 1959). Therapy in mild hypertension should be directed to control MI and alternative methods of treatment are available. Modified fat and salt poor diets, daily exercise, eliminating tobacco and avoiding stressful occupations has given impressive results in MI. Such a regimen has the advantage of correcting fat and cholesterol metabolism and sedentary living habits. Results with clofibrate show promise and future reports are awaited. An investigation of the toxicity of the hypotensive drugs is urgent.

Sincerely,
S. K. Robinson, M.D.

Attendance will be open to physicians and other health professionals.

Registration will begin at 8:00 AM.

No registration fee.

Contact: American Medical Association, 535 North Dearborn Street, Chicago, IL 60610

Del Webb Townhouse, San Francisco, Calif.

June 25-July 14—Rutgers Center of Alcohol Studies

Alcohol Studies

Interdisciplinary lectures and 19 specialized courses, including medical aspects of alcoholism, organizing and developing alcohol programs in a public health setting, alcoholism and public health nursing, and nursing services to alcoholic patients.

Fee: including tuition, room and board \$380.

Contact: Summer School of Alcoholic Studies, Rutgers University, New Brunswick, NJ 08903.

Rutgers University, New Brunswick, NJ

June 25-30—University of California, Los Angeles

The seventh annual Human Relations Laboratory for Nurses and Other Members of Hospital or Health Care Team.

Basic and advanced conferences, designed to help leaders release their fullest potential by practicing administrative and human relation skills, will meet separately but simultaneously and relate at certain points. Participants will be involved in both general sessions and small group meetings throughout the program conducted by specialists in applied human relations and social sciences who are widely experienced in the use of laboratory methods for leadership development.

Fee: \$295

Contact: Department of Conferences and Program Consultation, Room 515 University Extension, UCLA Los Angeles, CA 90024. Telephone—(213) 825-4801.

UCLA-Rieber Residence Hall, Los Angeles

July 5-14—Central States Institute of Addiction

Seminar on Addictions

Topics will cover: Aims and Purposes, Theory of Group Dynamics and Classification of Drugs on July 5/ Helping Relationships With Drug Users and Drug Abuse and the Educator, July 6/ Communication and Practice of Group Dynamics and The Drug Traffic July 7/ Communication Laboratory July 8/ Rehabilitation of the Addict-Abuser I and State Law and Procedures July 10/ Rehabilitation of the Addict-Abuser II and Some Socio-Medical Questions July 11/ The Role of Federal Law Enforcement and Psychology of Despair and Some Alternatives July 12/ Medical Treatment of Drug Abuse and Panel—Ex-Addicts on July 13/ and Social Meaning of Drug Abuse on July 14.

Tuition: \$200.00

Registration Fee: \$25.00

Contact: Central States Institute of Addiction 122 South Desplaines Street, Chicago, IL 60606

Telephone: 726-0821.

Central States Institute of Addiction, Chicago

Prescribe
the discoverer's brand
**Bactocill[®]*
(sodium oxacillin)**

*capsules equivalent to 250 mg. and 500 mg.
oxacillin and vials for injection equivalent to
500 mg. and 1 gm. oxacillin.

BMP

Beecham-Massengill Pharmaceuticals
Division of Beecham Inc. Bristol, Tennessee 37620

Doing little things better



caring better for her basic needs,
less confused in her thinking; no great
accomplishment for most people, but a
significant advance for the arteriosclerotic
patient with cerebrovascular insufficiency

Hydergine®

SUBLINGUAL TABLETS containing 0.167 mg. dihydroergocornine
methanesulfonate, 0.167 mg. dihydroergocristine methanesulfonate,
and 0.167 mg. dihydroergokryptine methanesulfonate

helps patients with cerebrovascular
insufficiency due to arteriosclerosis
do little things better

The usual dosage is four to six sublingual tablets daily. The patient's improvement with Hydergine is usually demonstrated in four to six weeks. Some nasal stuffiness due to adrenergic blockade, transient nausea or gastric disturbances have been reported with high dosages.

Obituaries

***Anderson, Dwight W.**, Decatur, died April 20, at the age of 70. He was a member of the American Academy of Family Physicians.

***Bellini, Albert C.**, Chicago, died April 27, at the age of 68. He began his medical practice in 1931 after graduating from the Loyola University School of Medicine and opened his offices in Chicago. During his 40 years of practice, he was on the staff of Mercy, Alexian Brothers and St. Joseph Hospitals.

***Berkwits, Edward**, Chicago, died January 6, at the age of 45. He was certified by the National Board of Medical Examiners and the American Board of Family Practice.

****Clark, Floyd M.**, Danville, died March 27, at the age of 81. He was a member of the boards of Lake View Memorial and St. Elizabeth Hospitals. Dr. Clark was a physician in the Danville area for 50 years.

Gregory, Gus, Chicago, died April 10. He was an active staff member at St. James Hospital since June, 1948. He interned and served his residency at Cook County Hospital.

****Haughton, Nicholas J.**, Greenup, died April 8, at the age of 92. He practiced medicine in Cumberland and northern Jasper Counties, for more than 50 years.

***Marchlewski Eugene F.**, Lockport, died April 16, at the age of 51. He practiced medicine in Lockport for 18 years after moving there from Chicago.

McGinnis, Thomas E., Lincolnwood, died April 1, at the age of 58. He was the manager of exhibits and meeting arrangements for the American College of Surgeons. Mr. McGinnis became associated with the organization as assistant to the controller 26 years ago and was given charge of convention management and medical-related industrial exhibits in 1950. He was a former president of the Conference of Medical Society Executives of Greater Chicago.

Mullen, Timothy F., Seneca, died April 20 at the age of 68. He was an instructor in orthopedics at the University of Illinois Medical School and gave clinical instruction at the Illinois Research Hospital from 1928 to 1933. He had a private practice in Chicago at that time. He was on the staff at the Community Hospital in Ottawa.

***Orr, Francis Nicholas**, Brighton, died April 16 at the age of 69. He was a member of the staffs of St. Joseph's and St. Anthony's Hospitals in Alton. He was also a past president of St. Joseph's Hospital staff. Dr. Orr was honored by the Macoupin County Health Association for establishing the Immunization Program for students in public schools in Macoupin County.

Pieczynski, John Leo, Chicago, died December 25 at the age of 71.

***Platt, Samuel S.**, Chicago, died April, 1972.

***Plice, William Andrew**, Chicago, died December 19, at the age of 101.

***Romanski, Arthur F.**, Western Springs, died March 27 at the age of 59. He was a staff member of MacNeal Memorial Hospital.

***Scott, Jordan Jueles**, Chicago, died April 1 at the age of 49. He began his practice in Chicago in 1958, and he served as medical staff treasurer at St. Francis Xavier Cabrini hospital. He was also a member of the American Academy of Family Physicians.

***Tan, Cecelio**, Lombard, died April, 1972, at the age of 43. He had offices in Lombard and was a staff physician at Memorial Hospital of DuPage County, Elmhurst.

****Warszewski, Edward H.**, died April, 1972. He was a physician for more than 50 years.

Watson, Earl M., Evanston, died April, 1972, at the age of 92. He was a surgeon at various times for the Northern Pacific R.R. and the Milwaukee Road. He was also a former health officer in Fargo. Dr. Watson came to Chicago in 1954.

***Wicks, Mark**, Chicago, died April 2, at the age of 62. He was a graduate of Northwestern University and maintained an office in Chicago for many years. Dr. Wicks was also a diplomate of the American Society of Abdominal Surgeons.

***Young, Worling**, Geneseo, died April 4, at the age of 69. He was a prominent Geneseo surgeon and served as president of the Henry County Tuberculosis Sanitarium Board.

**Denotes a member of ISMS.*

***Denotes member of 50-year Club and ISMS.*

PULSE ● ● ● *of the doctor's wife*

BY MRS. ROBERT HART, PULSE EDITOR

From the President's desk . . .

I HOPE MANY of you have accepted the invitation to participate with me the honor bestowed on the WA/AMA on their 50th Anniversary at the National Convention in San Francisco. Many of our Illinois Auxilians are represented (delegates and alternates listed below), and we have three members on the national slate of officers for 1972-73; Mrs. Willard Scrivner, President-elect, Mrs. Wendell Roller, Vice-President, and Mrs. Sherman Arnold, North Regional Director of AMAERF.

Our meetings and conventions are the most direct way to get to know you, and I look forward to being with you. Be sure to mark your calendars now for our fall district meetings.

Linia Martinucci

President.

National Convention Delegates who were elected in March and who will be reporting to you in future issues of PULSE are:

DELEGATES:

Mrs. August Martinucci, Chairman of the Delegates and Presidential delegate
Mrs. David Kweder, will deliver the Illinois State Message
Mrs. Sherman Arnold
Mrs. Newton Dupuy
Mrs. Robert Hartman
Mrs. H. Frank Holman
Mrs. Harold Keegan
Mrs. William Schowengerdt
Mrs. Mitchell Spellberg
Mrs. Eugene Vickery
Mrs. Wilson West



This picture shows some of the participants who enacted the comical membership skit chaired by Mrs. Willard Scrivner, "What? Me Join the Auxiliary to Podunk County Medical Society? BAH! Seated, Mrs. Allan Goslin; Left to right Mrs. Lowell Neveln, Mrs. Arthur Smith, and Mrs. John Ovitiz, Jr. A copy of the skit is available to county auxiliaries.

ALTERNATES:

Mrs. Gaetano Buttice
Mrs. Clement Cunningham
Mrs. Emanuel Feinhandler
Mrs. Homer Fleisher
Mrs. John Koenig
Mrs. Donovan Stiegel
Mrs. Julius Venkus
Mrs. Ralph White

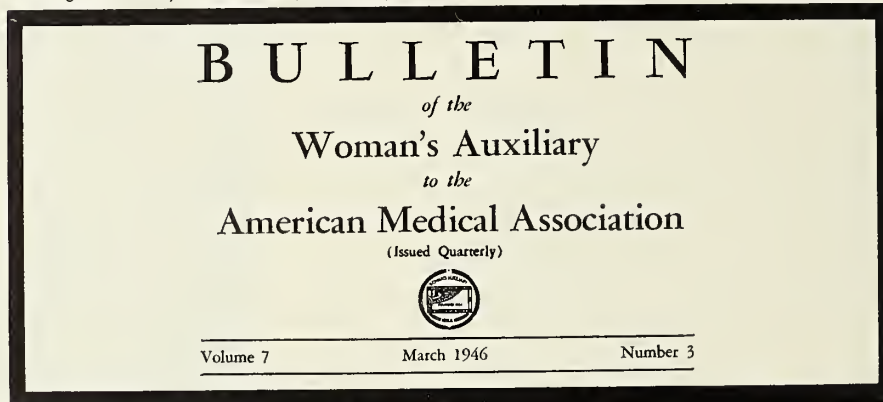
Combined District Meetings Dates Finalized

September 12—District Host—Cook County
Combined Districts 1, 2, 3, 11
October 17—District Host—Peoria County
Combined Districts 4, 5, 6, 7, 8,
November 9—District Host—St. Clair-
Belleville
Combined Districts 9, 10

MARCH 1972/75¢

md's wife

The Magazine for Physicians' Wives, published by the Woman's Auxiliary to the American Medical Association, Inc.



The new look in the publications of the Woman's Auxiliary of the AMA is illustrated by logo of MD's Wife, the magazine for Physicians Wives, published by the Woman's Auxiliary to the AMA. Inset below the new logo is long known emblem of the Bulletin on earlier publication of the Woman's Auxiliary to AMA. Bulletin was a quarterly which informed membership of activities for many years. Both the contemporary edition and the older publication were designed as working tools for Auxiliary Membership.

BY MRS. GURTRUDE EGAN

This seems to be the year of nostalgia-fashions, movies of the 30's and 40's to name a few. So it is fitting that we look back from our *NOW* "MD's Wife" publication to the *THEN* "Bulletin."

Recent Pulse pages have looked back to the beginnings of our National Auxiliary (1922) and to the Illinois State Auxiliary (1927). This month we give you "MD's Wife" background.

Prior to 1939 there had been mimeographed National News letters, however, many felt that we needed a more dignified and detailed national publication. So the Bulletin was born and the first issue printed in 1939.

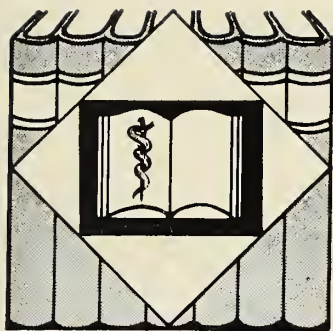
Mrs. James P. Simonds, Chicago, was the force behind this new venture. Fittingly, she was the first editor. Mrs. Simonds had high ideals for our National publication. She and her co-workers wanted it to be a medium to knit the members together by giving the state and county auxiliaries (especially the officers on all levels) a source of information to carry on the work.

We would be amiss not to mention the many attributes of our first editor. Quoting from the

Sept. 1961 issue of the Bulletin, "All of us when we think of the Bulletin think of Mrs. Simonds. She was so much a part of it. She was the first editor (1939) and continued as such until 1956. Her background knowledge of all auxiliary work and her keen mind did much to make the Bulletin what it is today. I can hear her say, "The Bulletin is a working tool—not a magazine." She strived for and achieved a dignified publication.

Now in 1972 demands on our publication are different from those of the 40's and 50's. We have matured. Today our national publication, *MD's Wife*, has a new format, it is colorful and interesting. We have come a long way from 1939 with the plain white cover, nine by six inch issues. That is as it should be, nothing should be static. Our new publication is in fact a valuable working tool fashioned with the most modern publishing techniques.

The editors that followed Mrs. Simonds are Mrs. E. M. Egan, Chicago, 1956-1961, who had been co-chairman 1953-1956; Mrs. John Wagner, Penn. 1961-1971; and the present editor, Mrs. J. Paul Sauvageot, Ohio. The "Bulletin" laid the foundation. "M.D. Wife" builds higher and better. We wish it well at age 33.



the doctors library

Ellison's Atlas of Surgery of the Stomach and Duodenum. By L. C. Carey and R. H. Albertin. Published by C. V. Mosby Company, St. Louis, Mo., 1971. \$24.50.

Begun by Dr. Ellison before his untimely death, this new Atlas of Surgery has been completed by his colleagues and associates, and serves as a tribute to the technical skill of a great surgeon.

Through 165 beautifully illustrated pages, Dr. Ellison's technique for performing many of the most common upper abdominal operations is described. Although the text is brief, many of the maneuvers which make difficult operations appear simple in the hands of a master, are included. The Atlas is extremely well illustrated allowing the reader to follow complicated dissections with ease.

The authors make no pretense about including complete discussions of surgical indications, or descriptions of alternate approaches. The authors are content to describe in a straightforward, easily understood manner, Dr. Ellison's techniques. As a result, this new Atlas must be included in the long list of valuable contributions to surgery by Dr. Edwin H. Ellison.

Stuart M. Poticha, M.D.

The Human Heart. By Brendan Phibbs, M.D., 1971, C. V. Mosby Company, p. 247.

Dr. Phibbs has recently updated his 1967 book, *THE HUMAN HEART* and added some authoritative text by Lane Craddock, George C. Griffith, Robert T. Patrick, and Colin H. M. Walker. The book prepares the patient and his family for the confusing and often frightening trip to the cardiac catheterization laboratory and explains what may be expected from cardiovascular surgery. The anatomy and physiology of the heart are presented in sufficient detail to clarify the simplified descriptions of all of the common types of heart disease. The benefits and risks of cardiac drugs are compared to friendly tigers: "When the physician keeper is not at hand, the tiger can rend and claw; properly controlled it can hold at bay the ogres of infirmity and death."

Both of these books select a common word in preference to a technical term wherever possible and find homely examples to make difficult medical concepts readily understood by non-medical people. We could use more books like these to help people understand their medical problems.

William H. Wehrmacher, M.D.

★ *MD's Must Report Gunshot Wounds*

Illinois law now requires physicians and nurses to report gunshot wounds as well as injuries believed to have been sustained during a criminal offense.

The bill, which amended the Criminal Identification and Investigation Act, was signed into law last fall by Governor Ogilvie and applies to "operators" of hospitals, clinics and other "medical facilities" in addition to physicians and nurses.

The report must be made "as soon as treatment permits" in all cases "when it reasonably appears" that an injury resulted from discharge of a firearm or was "sustained in the commission of—or as a victim of—a criminal offense."

The physician, nurse or hospital is free from civil liability for "reasonable compliance" with provisions of the law.

Changes in nitroglycerin tablet packaging and labeling

ON February 24, 1972, the U.S.P. announced that the following changes were being considered for labeling and packaging of Nitroglycerin Tablets:

1. Manufacturers must package Nitroglycerin Tablets in tight containers, preferably of glass;
2. A container shall hold not more than 100 tablets;
3. The labeling must indicate that the tablets are to be dispensed in the original, unopened container;
4. The label of all containers, including those on the container dispensed to the patient, must bear a statement directing the user to keep the tablets in the original container, and to close tightly between uses.

It is expected that these changes will be announced in an Interim Revision Announcement to U.S.P. XVIII. Manufacturers would be given about six months to comply.

Dr. Ralph F. Shangraw of the University of Maryland, and Chairman of the U.S.P. Subcommittee on Formulations, has recently submitted data that emphasizes the problem of improper packaging of Nitroglycerin Tablets and warns that immediate action is necessary to protect users of this drug.

In the first week of March, Dr. Shangraw, in his laboratory, analyzed Nitroglycerin Tablets which had been dispensed three months earlier in a clear, plastic vial with the label placed inside the bottle. The tablets had lost 84% of

labeled potency. In addition, 4,000 micrograms, equivalent to the active ingredient in ten tablets, was recovered from the label.

Dr. Shangraw also conducted experiments in which small numbers of fresh Nitroglycerin Tablets were packed in a tight, screw-cap, glass vial with a large amount of filler such as cotton. (Five 0.4 mg tablets and one gram of filler). After one week, the tablets packed with absorbent cotton lost about 75% of labeled potency.

Additional assay tests were conducted on Nitroglycerin Tablets that had been placed in a container with aspirin tablets. The aspirin tablets were found to absorb significant amounts of nitroglycerin (two aspirin tablets absorbed 200 mcg in one week).

Dr. Thomas J. Macek, Director of U.S.P. Revision, joins Dr. Shangraw in recommending the following restrictions be observed until the new U.S.P. regulations are put into effect:

1. Dispense Nitroglycerin Tablets only in glass vials with screw caps. Never use plastic prescription containers;
2. Never place a label inside the container;
3. Use the smallest vial that will hold the quantity of tablets prescribed;
4. Use a minimum amount of cotton filler;
5. Caution patients to never transfer Nitroglycerin Tablets to other containers and never place other types of tablets into a vial containing Nitroglycerin Tablets;
6. Do not strip package Nitroglycerin Tablets.

New Official Drug Order Forms

EFFECTIVE May 1, 1972, only Bureau of Narcotics and Dangerous Drugs Official Order Forms became valid for transactions involving Schedule I and II controlled substances. Any practitioner may obtain the new forms by forwarding the old type IRS order form requisition (IRS Form 679) to the BNDD Registration

Branch, P.O. Box 28083, Central Station, Washington, D.C., 20005.

The registrant's complete, nine-character BNDD registration number must be shown on the form in order that it may be processed. IRS Form 679 will not be honored as a valid requisition for official order forms after April 30, 1972. Therefore, this type of requisition should be submitted as soon as possible. Any registrant who does not now have an IRS requisition, and who desires the new order forms, is required to complete form BND 222D and forward it to the Registration Branch. The BND 222D forms may be obtained from any BNDD Regional Office.

Controlling Allergic Parotitis the view box

(Continued from page 541)

ing severity for five years. When, for cosmetic reasons, it was imperative to "do something for her," Cortico-steroid was administered with surprisingly dramatic improvement, temporarily. This stimulated a vigorous search for a previously suspected allergic cause. A four day fast in the hospital produced marked improvement until the accidental ingestion of fluoridated water precipitated swelling of the parotids (Fasting patients routinely drink only pure spring water). Cytotoxic tests showed allergy to legumes (mostly soybeans and peanuts), milk, corn, wheat and cottonseed. This was confirmed by provocative food tests and neutralization. For almost two years, she has been symptom-free with frequent hyposensitizing injections of these foods (except cottonseed), and moderated intake.

The Patient's Story

Pertinent and interesting facets of this patient's story are: (1) because of severe infant colic, she was fed with a soybean formula from the age of one month to five months; (2) throughout childhood, she refused all vegetables for the most part, except beans; (3) fluoridated tooth paste had already been proven as cause of aphthous stomatitis and gingivitis; (4) sialograms confirmed distal duct dilatation typically seen and described in the literature; (5) the exquisite sensitivity to soybeans is further exemplified by the extremely high dilution necessary to neutralize and treat. Needless to say, all attempts to find a stricture, caluuli or infection were without success. The fact that she has been almost completely symptom free on this regimen for almost two years as compared with the previous five years further validates our conclusion that this is a proved instance of parotid swelling due to food allergy.

Provocative tests for inhalent allergies are accepted, though not used as frequently as they should be. Provocative tests for foods are even less well known and used, but should be. While the mechanism or neutralization of provoked symptoms in food tests is not known (is it immunologic? is it enzymatic?), and the cytotoxic food test is only now being extensively tried, the dramatic results here point up their great clinical value. ◀

(Continued from page 542)

DIAGNOSIS: Diverticulitis—Diverticulitis can occur in any segment of the bowel but the sigmoid and descending colon respectively are the most common sites. Sometimes a segment several inches long may be affected. The patient demonstrates a perforation which produces an extra luminal pericolic, inflammatory mass or abscess that deforms and compresses one wall often in an eccentric fashion. In this case an extravasation of barium is leaking out into the peritoneal cavity. Sometimes small submucosal fistulous tracts or sinus tracts can be demonstrated extending into the inflammatory mass. Fistulous connection to the bladder, vagina or skin can occur.

Typically the lesion appears as a relatively long, narrowed, sometimes irritable segment in the sigmoid with thickened mucosa, an extra luminal pressure deformity along the wall and evidence of possible diverticula in the segment.

In patients with suspected acute diverticulitis, barium enema should be performed cautiously in order to avoid traumatic acute perforation. Roentgenological distinction from neoplasia may be difficult or impossible in some cases. Findings that favor the diagnosis of diverticulitis are preservation of the mucosal folds, gradual transition from diseased to normal colon, a rather long segment of involvement, and the presence of other diverticula.

ekg of the month

(Continued from page 547)

Answers:

A) 1,3 There is diffuse elevation of the ST segments, without reciprocal depression. This is typical of acute pericarditis. However, the abnormal Q waves in II, III and AVF are not seen in just pericarditis, so imply inferior wall infarction which could be acute or remote.

B) 1,3,4 A typical rub has three components, one in systole with ventricular contraction, and two in diastole with the timing of an S₃ and an S₄. However rubs frequently have only one or two components. During the course of acute myocardial infarction a rub is commonly heard, indicating irritation of the pericardium. Anti-coagulants are generally contraindicated in this situation as bleeding into the pericardial space can occur.

The negative power of clinically significant anxiety
in angina pectoris...



This man feels he is living
on borrowed time.

During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study, Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)*

Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

**The positive power of
adjunctive
Librium®
(chlordiazepoxide HCl)
10-mg, 25-mg capsules
up to 100 mg daily**

**for moderate
to severe anxiety
accompanying angina pectoris**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

index to volume 141

January through June 1972

Page: 1- 96 January
 97-242 February
 243-330 March
 331-424 April
 425-514 May
 515-594 June

A

Abdominal trauma in children, Management of
 (Trauma Center) (Raffensperger) 373
 Abstracts of Board actions (Convention Summary) 448
 Actions and Resolutions (Convention Summary) 492
 Adrenal Cyst (Beal, ed.) (Surgical Grand Rounds) 212
 Allergic Parotitis from foods, (Interlandi) 541
 Autopsy (Frankel) 543

B

Beal, J. M., ed. (Surgical Grand Rounds), 33; 212; 284;
 362; 467; 551
 Benedek, T., Skin manifestations of Hypovitaminosis
 A 460
 Berlinger, F. G., hypothyroidism 537
 Bicycle spoke injuries, (Kravitz) 464

BOARD ACTIONS, abstracts 448
 BOARD OF TRUSTEES 1972-73, Officers and (Conven-
 tion Summary)
 Bomberger, C., jt. author, Comparative study-Myfadol
 and meperidine as postoperative analgesics (Shul-
 man and Sadove) 293
 Boyd, David R., jt. author, (Trauma Center)
 Illinois statewide trauma care system 56
 The management of penetrating wounds of the ab-
 domen with simultaneous bowel and vascular in-
 juries 222
 Burg, Frederick, jt. author, Car restraint devices de-
 signed for children (Diamond) 390

C

Calderone, Mary, Sexual Pressures in Society 544

Campione, Kenneth M., Heart to head circulation time 75

Car restraint devices designed for children, (Diamond and Burg) 390

Chicago Symphony Orchestra—Touring Europe (Kaplan) 472

CLINICS FOR HANDICAPPED CHILDREN 80; 124; 270; 402; 510; 568

Choosing the safest ski binding, (Hugh A. Johnson) 238

Comparative study of—Myfadol and meperidine as postoperative analgesics (Shulman, Sadove and Bomberger) 293

Conference abstracts—Changing face of health care delivery—ISMS leadership (**Special Article**) 38

CONVENTION HANDBOOK

House of Delegates 134

Officers and Administration 138

Economics and Peer Review 153

Education and Manpower 158

Environmental and Community Health 161

Finances and Budgets 168

Governmental Affairs 174

Medical-Legal 178

Mental Health and Addiction 180

Public Relations and Membership Services 185

Social and Medical Services 187

Resolutions 188

CONVENTION, Highlights of (**Convention Summary**) 483

CONVENTION SUMMARY

Abstracts of Board actions 448

1972-73 Officers and Board of Trustees 482

Highlights of Convention 483

Summary of House of Delegates Actions 64

Actions and Resolutions 492

D

DeHaen, Paul (**New Pharmaceutical Specialties**) 78; 232; 302; 480; 565

Delegates Handbook (**Convention**) 129

Diamond, Eugene F., jt. author, Car restraint devices designed for children (Burg) 390

DOCTORS LIBRARY 414; 479; 577

E

Earlier and better eye care for children (Fortier) 455
Ectopic Pregnancy (Beal, ed.) (**Surgical Grand Rounds**) 284

EDITORIALS

HEW—A federal conglomerate 11

Guest Editorial—Giving to AMA-ERF 11

The treatment of gonorrhea in the female 216

"Turf" and Illinois new medical schools 261

Sudden death . . . premonition of things to come 392

Eat what you like 563

The Absent Constituency 564

Ehrhardt, Anke A., jt. author, Prenatal hormones and human behavior (Money) 386

EKG OF THE MONTH 37; 215; 287; 366; 463; 547 (Tobin, Nemickas, Scanlon, Moran and Talano)

Eye care for children, Earlier and better (Fortier) 455

F

Firor, Hugh V., Management of congenital defects of the anterior abdominal wall 71

Flashner, Bruce A., jt. author, (**Trauma Center**) Illinois statewide trauma care system (Boyd and Mains) 56

Fortier, Edward G., Earlier and better eye care for our children 455

Frankel, Gerald A., Autopsy (**Special Article**) 543

Franklin, James L., jt. author, Ulcerative colitis (Kirsner) 277 Part I, 355 Part II

Fruin, L. T. (**The President's Page**) 6; 106

H

Handicapped children, clinics for 124; 270; 402; 510; Hartman, Robert E., **Maternal death study—case reports** 291; 379; 471; 559

Heart to head circulation time (Kenneth M. Campione) 75

Highlights of Convention (**Convention Summary**) 483
House of Delegates actions, Summary of (**Convention Summary**) 489

Hypothyroidism, (Berlinger) 537

I

Illinois statewide trauma care system (**Trauma Center**) 56

Illinois Society, medical assistants 312

IMAA Report 241

Initial Care of the Critically Injured (**Trauma Center**) 474

Interlandi, Joseph, Allergic Parotitis from foods 541

ISMS Leadership—the changing face of health care delivery—Conference abstracts (**Special Article**) 38

J

Jayaraman, V. D., jt. author, Autotransplantation of splenic tissue—splenosis (Neiman and Sreiber) 556

Jirka, F. J. (**President's Page**) 258; 344; 440; 528

Johnson, Hugh A., Choosing the safest ski binding 238

K

Kaplan, Philip, Chicago symphony orchestra—touring Europe (**Special Article**) 472

Kirsner, Joseph B., jt. author, Ulcerative colitis Part I 277; Part II 355

Kravitz, Harvey, Bicycle spoke injuries 464

Kweder, Adele, Illinois should have an auxiliary. (**Pulse**), 416

L

- Landrigan, Philip J., Measles in previously vaccinated children in Illinois 367
 Larson, Norman E., jt. author, Retroperitoneal and gluteal cystic lymphangioma 381
 Lasting effects of early nutrition, (Parham) 27

M

- Mains, Kenneth D., jt. author, (**Trauma Center**) Illinois statewide trauma care system 56
 Management of abdominal trauma in children (**Trauma Center**) (Raffensperger) 373
 Management of congenital defects of the anterior abdominal wall, (Hugh V. Firor) 71
 Management of the penetrating wounds of the abdomen with simultaneous bowel and vascular injuries (**Trauma Center**) (Nyhus) 222
 Martinucci, Livia, (**Pulse**) "From your president . . ." 316
MATERNAL DEATH STUDY CASE REPORTS: No. 1 291; No. 2 379; No. 3 471; No. 4 559 (Hartman)
 Measles in previously vaccinated children in Illinois, (Landrigan) 367
 Medical assistants, Illinois Society 312
MEMBERSHIP FORUM 393; 570
 Money, John, jt. author, Prenatal hormones and human behavior (Ehrhardt) 386
 Moran, John R., jt. author, see Tobin, John R. (**EKG of the month**)

N

- Neiman, B. H., jt. author, Autotransplantation of splenic tissue—splenosis (Jayaraman and Schreiber) 556
 Nemickas, Rimgaudes, jt. author, see Tobin, John R. (**EKG of the month**)
NEW PHARMACEUTICAL SPECIALTIES (De Haen) 78; 232; 301; 480; 565
 Nitroglycerin tablet (Special Article) 578
 Nutrition, Lasting effects of early (Parham) 27
 Nyhus, Lloyd M., jt. author (**Trauma Center**) The management of penetrating wounds of the abdomen with simultaneous bowel and vascular injuries 222

O

- OBITUARIES** 85; 237; 304; 409; 499; 574
 Oviedo, Miguel A., jt. author, Retroperitoneal and gluteal cystic lymphangioma (Larson and Parent) 381

P

- Pancreatic transplantation (Beal, ed.) (**Surgical Grand Rounds**) 362
 Parent, Gerald, jt. author, Retroperitoneal and gluteal cysts lymphangioma (Larson and Oviedo) 381
 Parham, Ellen S., Lasting effects of early nutrition 27
PEER REVIEW 305
POLICY MANUAL of Illinois State Medical Society 63
PRACTICE MANAGEMENT 219; 302; 400; 498; 562
 Prenatal hormones and human behavior (Ehrhardt and Money) 386
PULSE OF THE DOCTOR'S WIFE 84; 238; 316; 416; 505; 575

R

- Raffensperger, John G., (**Trauma Center**) Management of abdominal trauma in children 373
 Resection of Myocardial infarct (Beal, ed.) (**Surgical Grand Rounds**) 467
RESOLUTIONS (Convention) 188
 Retroperitoneal and gluteal cystic lymphangioma (Oviedo, Larson and Parent) 381
 Romano, Teresa, jt. author (**Trauma Center**) Initial care of the critically injured 474

S

- Sadove, Max C., jt. author, Comparative study of—Myfadol and meperidine as postoperative analgesics (Shulman and Bomberger) 293
 Scalon, Patrick, jt. author, See Tobin, John R. (**EKG of the month**)
 Schreiber, R. David, jt. author, Autotransplantation of splenic tissue—splenosis (Jayaraman and Neiman) 556
 Sexual pressures in society, (Calerone) 544
 Shulman, Morton, jt. author, Comparative study of—Myfadol and meperidine as postoperative analgesics (Sadove and Bomberger) 293
 Ski binding, choosing the safest (Johnson) 238
 Skin manifestations of hypovitaminosis A (Benedek) 460
 Sloan, Michalyn (Special Article) 299
SOCIO ECONOMIC NEWS (Lotharius) 83; 229; 317; 412
 Summary of House of Delegates Actions (**Convention Summary**) 489
SURGICAL GRAND ROUNDS (Beal, ed.)
 "Thymoma with myasthenia" 33
 "Adrenal cysts" 212
 "Ectopic pregnancy" 284
 "Pancreatic transplantation" 362
 "Resection of myocardial infarct" 467
 "Submaxillary gland cylindroma" 551

T

- Talano, V., jt. author, See Tobin, John R. 366
 The changing face of health care delivery—ISMS
 Leadership, Conference abstracts (Special Article) 38
THE PRESIDENT'S PAGE (Fruin) 6 and 106
 (Jirka, Jr.) 258; 344; 440; 528
 Thymoma with myasthenia (**Surgical Grand Rounds**)
 33
 Tobin, John R. ed., Moran, Nemickas, Rumgaudas,
 Scanlon and Talano (**EKG of the month**) 37; 215;
 287; 366; 463; 547
 Touring Europe—Chicago Symphony Orchestra (Kap-
 lan) 472
TRAUMA CENTER
 Illinois statewide trauma care system 56
 The management of penetrating wounds of the ab-
 domen with simultaneous bowel and vascular
 injuries 222
 Management of abdominal trauma in children 373
 Initial care of the critically injured 474
 Fluid therapy in hemorrhagic shock 548

U

- Ulcerative colitis—clinical, diagnostic and therapeutic
 aspects (Franklin and Kirsner) Part I 277, Part II
 355

V

- VIEW BOX** (Love) 32; 211; 283; 361; 459; 542
 Vickery, Millie (Pulse)
 A 50th birthday celebration is coming 84
 The word is out—Flower Power 238

W

- WHAT GOES ON:** 89; 234; 326; 418; 503; 567

Advances in medico-legal affairs

California physicians have been successful in having state legislation passed to freeze the present interpretation of *ipsa res loquitur* and to lower the statute of limitations to one year from the time of discovery or four years from the date of injury. . . .

Other legislation has been enacted to protect committee members of the medical staff and county medical societies on their recommendations and protect the records of medical review committees of medical staffs and medical societies from discovery. Legislation has also been passed to protect physicians rendering emergency medical care arising from the previous care of another physician and to protect rescue and resuscitation teams from liability for acts or omissions while attempting to resuscitate a patient in immediate threat of death.

Still other laws provide that any advance payment by an insurance carrier to an injured party shall not constitute an admission of liability and require the posting of a \$500 bond by plaintiff's attorney. (Malcolm C. Todd.: **Skin & Allergy News**, Dec., 1971, pp. 3-22.)

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed 12 to 13 manuscript pages, (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for

the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

T. R. Van Dellen, M.D., Editor
 Illinois Medical Journal
 360 N. Michigan Ave.
 Chicago, Ill. 60601.

Scientists use computer to detect Cystic fibrosis in newborn babies

One child in 2,500 is born with cystic fibrosis, a disabling and eventually fatal disease for which there is no known cure.

Now an IBM computer and a group of Texas A&M scientists have teamed up to spot the illness in newborn babies through analysis of their fingernails. Early detection can add many years to their lives.

A&M is performing the analyses for a project headed by Dr. Guyon Harrison of Baylor College of Medicine in Houston. Dr. Harrison hopes to develop a mass screening capability that eventually would allow every newborn child to be tested for cystic fibrosis.

The testing is done in the Activation Analysis Research Laboratory, headed by Dr. R. E. Wainerdi, under the direction of Dr. L. E. Fite.

"In general, children with cystic fibrosis have a life expectancy of five to 15 years," Dr. Wainerdi said. "Early detection and proper treatment can allow them to live up to four times longer."

Researchers found that the fingernails from many patients with cystic fibrosis contained several times the normal amounts of copper, sodium chloride and phosphorus. The A&M team chose copper as the measurement least likely to be distorted by contamination.

"The fingernails of normal newborns contain from two to thirty parts per million of copper," Dr. Wainerdi said. "The nails of children with cystic fibrosis demonstrate copper concentrations of from 50 to 200 ppm."

The research group then worked out a precise test procedure using neutron activation analysis.

"Fingernail clippings are received from cystic fibrosis centers across the country," Dr. Fite said. "The samples and a copper standard are then irradiated, making the various trace elements radioactive."

Then the IBM System/360 Model 65 compares the fingernail radioactivity readings against the reading from the copper sample and reports the parts-per-million copper content of the nail clipping. The entire procedure takes only a few minutes.

"Medication and treatment can allow the cystic fibrosis victim to lead a reasonably comfortable life," Dr. Harrison explained, "but his life expectancy at best is only half the normal span. Medical science has found no way to treat the disease—only the symptoms."

Cystic fibrosis is essentially hereditary and limited to Caucasians. Its victims invariably are children of exceptional intelligence.

The disease creates pancreatic enzyme deficiencies and keeps the exocrine glands from functioning properly. As a result, the child with cystic fibrosis often has a persistent infection of his respiratory system that produces progressive damage and is the disease's major life-threatening complication.

Weight loss and the heart

". . . most of the circulatory effects of marked obesity are reversible with weight loss. Reduction in body oxygen uptake reflects the decrease in metabolic demand with loss of tissue mass. Parallel reductions in cardiac output and circulating blood volume accompany the diminished oxygen transport required for a lesser total aerobic metabolism.

Since systemic vascular resistance remained unchanged after weight loss, the consistent fall in mean systemic arterial pressure and reduction in left ventricular afterload can also be linked to decreased total metabolic activity and cardiac output. It has been previously observed in a larger series of obese subjects that systemic vascular resistance was either normal or subnormal. These studies emphasize the advantage of weight reduction in the management of hypertension accompanying exogenous obesity over the use of agents to reduce systemic vascular resistance. (James K. Alexander and Kirk L. Peterson: Cardiovascular Effects of Weight Reduction, *Circulation*, Feb., 1972, pgs. 310-318.)

Report Suspected Child Abuse

A recently enacted amendment to the state Child Abuse Law requires reports from medical practitioners in cases of children "whose death occurs from apparent injury, neglect, or malnutrition." According to Director Edward T. Weaver of the state Department of Children and Family Services, Physicians and hospital administrators are now required to report all cases of suspected physical abuse of children, including child deaths. Until now, the language of the statute did not clearly indicate whether reports were required in cases in which a child was already dead from injuries or neglect at the time medical authorities were notified, Weaver emphasized.

Under provisions of the Child Abuse Law, physicians, hospital administrators, and other medical practitioners are required to report to the Department of Children and Family Services all suspected cases of abuse within 24 hours of the medical examination of the child. The law gives immunity from prosecution.

The department is required to investigate each case, offer protection to the child and other youngsters in the family when necessary and provide family rehabilitation social services.

Weaver contends that it is extremely important for his office to be alerted to suspected cases of child abuse so that child welfare workers can extend any necessary protection to other children in the family. He says that statistics show that there is an average of three children in families in which child abuse is suspected. Frequently more than one child is abused. Some 723 cases of suspected child abuse have been reported to the department by physicians.

This record number of reports does not necessarily mean that the child abuse problem is growing more acute. The volume of reports may merely reflect the fact that doctors and hospital personnel know about the law and are carrying out their reporting responsibilities.

The director observed that the number of child deaths from suspected abuse reported to the department's central registry has declined in recent years. "The new wording of the law will help us determine whether there has, in fact, been a significant reduction in the number of child deaths from physical abuse or whether some deaths have not been reported to us," Weaver told *IMJ*.

Physician



A well-known, research-oriented institution in western suburban Chicago requires the part time services of a Physician for a well-equipped clinic facility. This Physician will provide health examinations for company personnel and prospective employees in routine type office medicine.

Approximate time required is 20 hours per week — specific hours are flexible and a convenient schedule can be arranged that dovetails with the Physician's other commitments.

Please reply in confidence, including salary requirements to:

Box 799 c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

An equal opportunity employer—M/F

APPROVED

AVAILABLE NOW! ISMS MALPRACTICE INSURANCE

**Professional Liability Insurance
Program
Approved for Members
REGARDLESS of AGE
or SPECIALTY**

Protect Doctor's Integrity

Company will settle no claims without insured member's approval. Nuisance claims will be fought.

Improve Legal Climate

Company will retain outstanding defense counsels who are experts in professional-liability cases.

Provide Market Stability

Company will maintain an available market. Participation by the members is needed to assure this market.

Keep Members Informed

Company will tell members how to prevent claims . . . keep them aware of latest legal developments in malpractice field.

ISMS Supervision And Control

Premiums to reflect only the loss experience of ISMS. All questionable underwriting cases to be reviewed by ISMS. A UNIQUE FEATURE

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT ADMINISTRATORS:

PARKER, ALESHAIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

COOK COUNTY

Graduate School of Medicine

CONTINUING EDUCATION COURSES STARTING DATES—1972

SPECIALTY REVIEW COURSE IN SURGERY, Part I, August 7
SPECIALTY REVIEW COURSE IN ORTHOPAEDICS, September 11
SPECIALTY REVIEW COURSE IN THORACIC SURGERY, Sept. 11
SPECIALTY REVIEW COURSE IN NEUROLOGY, Clinical, Sept. 11
SPECIALTY REVIEW COURSE IN OB-GYN, October 16
ADVANCED PERIPHERAL VASCULAR SURGERY, One Week, July 17
MANAGEMENT OF COMPLICATIONS IN SURGERY, 4 Days, Sept. 12
SURGERY OF THE G.I. TRACT, One Week, September 25
FLUIDS & ELECTROLYTES, One Week, September 18
SURGERY OF THE HAND, Three Days, September 20
PEDIATRIC SURGERY, One Week, September 25
BLOOD VESSEL SURGERY, One Week, October 9
MANAGEMENT OF COMMON FRACTURES, One Week, October 23
CLINICAL ENDOCRINOLOGY, One Week, September 25
BASIC INTERNAL MEDICINE, One Week, October 2
BASIC ELECTROCARDIOGRAPHY, One Week, October 9
PULMONARY FUNCTION TESTS, Three Days, July 12
FAMILY PRACTICE REVIEW, One Week, October 30
CLINICAL ANESTHESIA PRACTICE, One Month, October 2

*Information concerning numerous other continuation
courses available upon request.*

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

HOME IN MALLORCA FOR \$15,000. FREE OLIVES.

500-year old olive trees will grace the terrace of your new home in Son Coll, a delightful international community on Mallorca's scenic Northwest coast. Private beach, swimming pool, tennis courts, bar-restaurant and shops make this unique resort a great place for vacations or year 'round living. Financing is available. Write us for information about Son Coll, and about our low-cost inspection tours. Travel expenses up to \$300 refunded if you buy.



Special Places for Special People

PANORAMA

International Real Estate
810 18th St., N.W., Dept. 36 AH
Washington, D. C. 20006
Phone: (202) 783-3600

Doctor's News

RADIATION CONFERENCE WARNS AGAINST OVEREXPOSURE—Two staff members of the division of radiological health in the Illinois Department of Public Health met in New Orleans in early May with 250 radiological health authorities from throughout the nation. According to Franklin D. Yoder, M.D., state health director, the fourth National Conference on Radiation Control focused on reducing unnecessary exposure from medical and environmental radiation.

HEALTH SERVICE COORDINATION PROGRAM ORGANIZED—Maxine Rosenbarger, M.D. announced the designation of the Health Services Coordination Program of Southern Illinois, Inc., as the comprehensive health planning agency for the 27 county southern Illinois region and the receipt of \$45,000 in state and federal money to fund the agency.

The designation and a \$25,000 grant come from the Health Services and Mental Health Administration of the Federal Department of Health, Education and Welfare.

The \$20,000 state grant is from the Comprehensive State Health Planning Agency. An additional \$10,000 will be raised locally.

As the comprehensive health planning agency for southern Illinois, the Health Services Program will be referred to as a "b" agency. This designation comes from section-314-b of the law creating comprehensive health planning passed by Congress in 1966.

HOSPITALS TO SCREEN WHITES FOR SICKLE CELL ANEMIA—The commission on Sickle Cell Anemia has recommended that hospitals begin screening everyone for the disease since the discovery that several whites in the Chicago area have traits of the disease.

COWS QUARANTINED TO PROTECT CONSUMER FROM INSECTICIDE—The Illinois Department of Public Health has quarantined a herd of cows of a dairy farm near Morrison, Ill., where some of the animals were accidentally poisoned. Franklin D. Yoder, M.D., state health director, explained that several cows broke into a shed where they consumed insecticide and treated seed corn stored there by the farmer.

No milk from the herd will be permitted to leave the farm until the Department of Agriculture reports to the Department of Public Health that the herd is cleared and milk samples are free of pesticide.

STATE PURCHASES BREATHALYZERS TO ENFORCE IMPLIED CONSENT LAW ON DRIVERS—Illinois will purchase 425 Breathalyzers, to implement the implied consent law as a result of bids opened in Springfield, according to David R. Boyd, M.D., of the state Department of Public Health. Implied consent goes into effect July 1 and operators for the Breathalyzer must be trained and certified by then.

WILL HIGHER COURTS UPHOLD H-3636—There is a serious question whether the courts will uphold H-3636, a bill giving the State exclusive powers to regulate doctors and nurses plus 28 other professions, which was signed by Governor Richard B. Ogilvie May 2. However, there is some reassurance by virtue of passage of this bill that Chicago and other municipalities will not start licensing MDs and RNs.

AHA CHALLENGES HILL-BURTON GRANTS—In a formal action by the American Hospital Association's Board of Trustees, hospitals are being asked "to challenge the proposed Hill-Burton regulations . . . as vigorously as possible on the grounds of their questionable legality and their unreasonableness."

The board also has called for "more appropriate guidelines and criteria" to be used in determining the amount of charity required of hospitals receiving Hill-Burton funds.

The Board action was taken May 4th in response to a proposal by HEW Secretary Elliot Richardson recommending that hospitals receiving Hill-Burton grants, loans or loan guarantees, provide free services to the poor at a level not less than 5% of operating costs, or not less than 25% of their net incomes, whichever is greater. Both IHA and AHA are currently studying the standards proposed by HEW for establishing minimum levels of free care that hospitals must give if they had previously been, or will be recipients of the Hill-Burton funds.

KOWALSKI NAMED MEDICAL SPORTSMAN OF 72—Julius M. Kowalski, M.D., an Illinois physician and surgeon has been named medical sportsman of the year by *Sports and Travel*, the leisure magazine for physicians.

DR. GEORGE A. WILTRAKIS ELECTED V.P. OF AMERICAN SOCIETY OF ABDOMINAL SURGEONS—Dr. George A. Wiltrakis of St. Charles, Illinois was recently elected vice president of the 10,000 member American Society of Abdominal Surgery at the 13th annual Clinical Congress, Chicago.

PANKOVICH APPOINTED CHAIRMAN OF DEPARTMENT OF ORTHOPEDIC SURGERY AT COOK COUNTY—James G. Haughton, M.D., executive director of the Health and Hospitals Governing Commission, announced the appointment of Arsen M. Pankovich, M.D., as Chairman of the Department of Orthopedic Surgery at Cook County Hospital.



Illinois Governor Richard B. Ogilvie (left) presents a plaque to W. H. West, M.D. (Center) from the Republican Central Committee and a life-time membership in the Belleville Republican Club. Also attending the presentation was V. P. Siegel, M.D. (Right), Chairman of IMPAC.

First President For Palos Heights Community Hospital To Serve In Newly Created Office



Samuel L. Hamilton, M.D. has been chosen to serve as the first medical staff president of Palos Heights Community Hospital. The new Hospital—a 265 bed facility located at 123rd and 80th Ave. in Palos Heights—opened a month ago. It is situated on 40 acres and is designed for expansion to a capacity of 1000 beds. Dr. Hamilton graduated from the University of Illinois Medical School.

Dr. Mervin Shalowitz, M.D. Elected To Board of Trustees of American Society of Internal Medicine

At the 16th annual meeting of the American Society of Internal Medicine Mervin Shalowitz, M.D. of Chicago, was elected to the Board of Trustees. A native of Chicago, Dr. Shalowitz is engaged in private practice at the North Suburban Clinic in Skokie, Ill. and is Medical Director of Intergrupp, a non-profit Illinois prepaid health service plan.



★
Specialized Service
 IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

**THE
 MEDICAL PROTECTIVE COMPANY**
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO AREA OFFICE: T. J. Pandak, J. C. Kunches, and L. R. Gannon, Representatives
 T. J. Hoehn, Consultant
 815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
 SPRINGFIELD OFFICE: W. J. Nattermann, Representative
 426½ South Fifth Street, Springfield 62701 (217) 544-2251

Thalassemia

Thalassemia is a disorder of hemoglobin synthesis in which decreased amounts of hemoglobin collect in the maturing red cell. The thalassemia syndromes are therefore classified among the hypochromic anemias. However, decreased cellular hemoglobin content is a tolerable condition because the normal marrow is capable of generating an increased number of red cells if iron stores are maintained. In thalassemia the hypochromic anemia is accompanied by excessive ineffective erythropoiesis and rapid destruction of many newly delivered erythrocytes, which greatly limits the compensating capacity of the marrow even though iron stores are excessive. The basis of this rapid destruction or ineffective erythropoiesis was delineated by Fessas and his associates, who emphasized that large inclusions of insoluble alpha chains occur in the erythrocytes and in the majority of bone-marrow erythroid precursors of patients with beta thalassemia. The thalassemia syndromes are therefore the results of unbalanced globin synthesis: in beta thalassemia alpha-chain inclusions occur, and in alpha thalassemia precipitated beta-chain inclusions are present. (David G. Nathan.: Thalassemia. *New England JI. of Medicine* (Mar 16) 1972, pgs. 586-594)

Cancer and children

This year cancer will take the lives of approximately 4,000 children under the age of 15. Almost half of them will die of leukemia, which is a cancer of blood-forming tissues. More school children will die of cancer than from any other disease. Today there are over 300,000 American children under 18 who have lost their fathers to cancer. Over 250,000 have lost their mothers.

1. Medical News Report 4:9 (Mar 6) 1972.

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

UNUSUAL OPPORTUNITY FOR PHYSICIANS who prefer not to maintain an office to join a rapidly growing fee-for-service group in the Emergency Department of Chicagoland hospitals. Flexible work schedules, 24-48 hours weekly. Prefer surgeons, general practitioners with experience in traumatic medicine, or those specifically interested in high standard Emergency Care. Group is expanding, developing teaching programs. Excellent facilities, automated billing and collecting service, opportunity for research in emergency procedures and programming. Ideal for physician desiring high remunerative compensation for circumscribed work. Address reply to: Medical Emergency Service Associates (MESA), S.C., 111 North Addison, Elmhurst, Illinois 60126. 832-4504.

OPENINGS FOR PHYSICIANS in Psychiatry, Internal Medicine or General Medicine. The Illinois Department of Mental Health invites physicians to apply for challenging positions in its mental health facilities. A comprehensive program of mental health and retardation involving community and inpatient programs is established throughout the State.

Openings are available for physicians who qualify for an Illinois License with approved training in Psychiatry, Internal Medicine or General Medicine.

Salaries for Illinois-licensed physicians range from \$24,000 to \$41,000 depending upon professional qualifications, experience and capability of assuming increasing professional responsibilities, i.e., Board Certified or Eligible Physician, commencing salary \$28,308.

Liberal benefits include life and health insurance, annual and sick leaves, retirement and social security.

Interested doctors should write to Mr. Bernard McLaughlin, Medical Staff Employment Administrator, Illinois Department of Mental Health, 160 North LaSalle Street, Chicago, Illinois 60601, or call collect—area code 312, 793-2748 or 2749, hours 9 a.m. to 4:30 p.m.

WANTED: OB-GYN, SURGEON AND INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. \$30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

FAMILY PRACTITIONERS, Fairfield, Illinois 6000 population—Excellent schools and recreational facilities for your family. Write or call collect; Jerry Vaughan, Box H, Fairfield, Illinois 62837—Telep. (618) 842-2167.

IMMEDIATE OPENING: INTERNIST OR GENERAL PRACTITIONER to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practicing physicians (General Practitioners) in the community outside of our Clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1 1/2 hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd. Two Rivers, Wisconsin 54241.

WANTED ASSOCIATE IN GENERAL PRACTICE. Join 2 men in established incorporated practice in large northern suburb of Chicago. Excellent schools and cultural advantages. Dealing primarily in internal medicine. No OB or Surgery. Practicing in 500-bed teaching hospital. Contact Bernard Berne, M.D., 603 Main Street, Evanston, Illinois 60202.

IMMEDIATE OPENING FOR OB-GYN, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

PHYSICIAN WANTED—Attractive, prosperous, residential community of Geneseo with over 6,000, serving a trade area of 29,000 population. Located on Interstate 80, 2 1/2 hours from Chicago and 25 miles east of Quad-Cities metropolitan area of over 300,000 population provides ideal, safe, small city living for family with excellent recreational facilities. New ultra-modern \$2,500,000 hospital with 110 beds. Office space and housing immediately available. Contact: Clement G. McNamara, 210 W. Elk Street, Geneseo, Illinois or phone collect: (309) 944-6431.

ENT STAFF PHYSICIAN—Progressive 400-bed community hospital has unique opening for young man wishing to establish the only private ENT practice in residential-industrial area southeast of downtown Chicago. For further information write or call collect Executive Director, South Chicago Community Hospital, 2320 E. 93rd Street, Chicago; telephone (312) 375-4400 or (312) 375-9802.

GENERAL SURGEON & FAMILY PHYSICIAN—2 men to provide health services in new community financed hospital in Jennings County, Indiana. No other hospital in county of 22,000. Three other general practitioners in county. New hospital equipped to provide many health services. Hospital Board will contract with the physicians for services. For further details, call Cory SerVaas, M.D. (317) 634-1100.

PSYCHIATRIST—Group therapy and individual student practice with some administrative duties. Salary per qualifications, fringe benefits; some private practice possible. Convenient to Metropolitan Chicago. Minimal qualifications: Residency completed and Illinois license. Phone or write: Loren W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, Illinois 60115. (815) 753-1311.

GYNCOLOGIST for large university health service. Prefer full-time physician wishing to practice in Chicago one day weekly. No major surgery or obstetrics. Salary per qualifications. Illinois license required. Contact L. W. Akers, M.D., Director UHS, Northern Illinois University, DeKalb, Illinois 60115.

PSYCHIATRIC STAFF—Requirements of 3 year residency training to Board Certified. \$26,000 to \$36,300 depending on qualifications and experience. Excellent Michigan Civil Service fringe benefits. Smog free, peaceful, cultural, summer-winter vacationland community. College town. Near Interlochen National Music Camp. 1400 bed progressive psychiatric hospital. J.C.A.H. approved. 3 year psychiatric residency program. Contact M. Duane Sommerness, M.D., Room 321, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

ASSOCIATE WANTED: GENERAL PRACTITIONER for extremely busy solo practice. 1970 gross income well over six figures. Ideal location in small Illinois community. New 100-bed hospital. 45 minutes from downtown St. Louis and 15 minutes from 26,000 acre Lake Carlyle. Excellent schools, churches, and recreation facilities. Salary arrangement or guaranty first year, leading to eventual buy-in. Write to Box Number 800, c/a Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

PHYSICIAN FOR HEALTH SERVICE STAFF For September 1, 1972 or earlier. 40 hours per week plus night duty every 16th night. One month vacation and other benefits. Equal opportunity employer. Salary to \$26,250 per year. Illinois License required. Appreciate full information first letter. L. M. Hursh, M.D. Director Health Services, University of Illinois, Urbana, Illinois 61801.

WANTED: GENERAL PRACTITIONER OR INTERNIST for large University Health Service. Salary per qualifications. Illinois license required. Fine facilities, good geographical location. L. W. Akers, Director, N.I.U., DeKalb, IL. 60115.

CLINICAL DIRECTOR (Psychiatry). Milwaukee County Medical Health Center. We are a community oriented center providing out-patient, in-patient and partial hospitalization for adults and children, and also providing community psychiatric clinics located in 6 catchment areas. Supervise psychiatric, neurological, medical and related services. Requires completion of approved 3 year residency in psychiatry, eligibility for Wisconsin license and a total of 7 years' experience or training in psychiatry. For further information contact: George E. Currier, M.D., Asst. Director, Mental Health, 9191 Watertown Plank Rd., Milwaukee, Wis. 53226. (414) 258-2040, Ext. 3440.

BOARD CERTIFIED RADIOLOGIST: Illinois State License, desires association, central or southern, community type hospital(s) preferred. Phone 618-532-1642.

FREEDOM, HAPPINESS, AND CHALLENGE!! Since you are reading this, you are probably dissatisfied with long hours, no free time for family or hobbies, cost of living, and/or your local community problems. We are looking for a skilled General Practitioner under 55 to join our 40-bed JCAH-accredited hospital and out-patient clinic. Manhattan is a town of 30,000 friendly people located in the beautiful, rolling Flint Hills with two large lakes, cultural attractions you wouldn't believe, recreation and sporting opportunities aplenty, regular 8-5 minimum call 3-4 nights per month, salary of \$24,000, one-month paid vacation. But more important, we offer freedom and happiness in a healthy and beautiful environment. It only costs 10c for more information since we can't tell you everything in this ad. R. E. Sinclair, M.D., University Hospital, Kansas State University, Manhattan, KS 66502.

PATHOLOGIST WANTED: Illinois licensed, board eligible or certified for vacation coverage in new hospital 90 miles SW of Chicago \$600 per week plus motel room. Contact James Gross, M.D. Pathologist, St. Mary's Hospital, Streator, Illinois 61364. Telephone: (815) 673-2311 Ext. 219.



X73-3311

Illinois medical journal.
v.141, 1972.

4/20/74

DATE	ISSUED TO
4/20/74	

X73-3311

Illinois medical journal.
v.141, 1972.

RETURN THIS BOOK ON OR BEFORE LAST DATE STAMPED

✓ APR 24 '74	RET'D. MAY 1 1974
APR 8 '75	RET'D. APR 8 1975
J NOV 14 '75	
RET'D. NOV 1 4 1975	
J FEB 11 '76	RET'D. FEB 5 1976
RET'D. AUG 30 '76	
OCT 6 '78	
OCT 1 1976	
OCT 31 '78	
NOV 8 '78	

